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No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

vs.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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EDITOR'S NOTE

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QUESTIONS PRESENTED

This action involves a medical insurance contract covering petitioner pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. Section 8901, *et seq.* ("FEHBA"). Section 8902(m)(1) of FEHBA provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

The United States Court of Appeals for the Ninth Circuit, based solely upon Section 8902(m)(1), held that petitioner could not maintain an action under California law against private insurance carriers to enforce petitioner's rights under a FEHBA medical insurance plan.

The questions presented are:

1. Whether FEHBA contains a comprehensive civil enforcement scheme intended by Congress to both displace and supplant state laws designed to regulate private insurers—that is, does FEHBA provide a superseding federal remedy that will accomplish the express purpose of FEHBA to provide federal employees with health insurance benefits co-extensive with those available to the private sector, at the lowest possible cost.

2. Whether petitioner's state law claims against private insurance carriers to enforce his rights to receive benefits under FEHBA are inconsistent with Section 8902(m)(1).

3. Whether the dispute between petitioner and respondents, private insurance carriers, is a private controversy, in which the federal government simply does not have an interest sufficient to justify federal court jurisdiction.

LIST OF PARTIES

The parties to the proceedings below were petitioner, KIP HAYES, and respondents, PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, and petitioner's father, NOBEL A. HAYES.

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No. _____

IN THE

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October Term 1987

KIP HAYES,
Petitioner,

vs.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Respondents.

PETITION FOR WRIT OF CERTIORARI

Petitioner, KIP HAYES, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, entered in the above-entitled proceeding on June 15, 1987.

OPINIONS BELOW

The order of the United States District Court, Southern District of California (Nielsen, L.C.) granting respondents' motion for summary judgment has not been reported. It is re-printed in Appendix "A," attached hereto.

The opinion of the United States Court of Appeals for the Ninth Circuit affirming the district court's order granting respondents' motion for summary judgment is reported at 819 F.2d 921 (9th Cir. 1987), and is re-printed in Appendix "B," attached hereto.

The order of the United States Court of Appeals for the Ninth Circuit denying petitioner's petition for rehearing in the Ninth Circuit Court of Appeals, is reprinted in Appendix "C," attached hereto.

JURISDICTION

Petitioner originally brought this action in the Superior Court of California, County of San Diego, on April 16, 1984. Thereafter, respondent NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES removed the action to the United States District Court, for the Southern District of California, alleging federal jurisdiction under 28 U.S.C. §§1331, 1332(a) and 1441.

Thereafter, respondents brought a motion for summary judgment seeking an order dismissing petitioner's state law claims on the grounds said claims were preempted by §8902(m)(1) of FEHBA. Said motion was granted by the district court on January 14, 1985.

Thereafter, petitioner filed a timely appeal to the Ninth Circuit Court of Appeals. On June 15, 1987, the Ninth Circuit Court of Appeals issued an order affirming the district court's order. A petition for rehearing was timely sought and subsequently denied on July 21, 1987.

On October 2, 1987, Justice O'Connor ordered that the time for filing the petition for a writ of certiorari be extended to and including November 18, 1987.

The jurisdiction of this court to review the judgment of the Ninth Circuit is invoked under 28 U.S.C. §1254(1).

STATUTES INVOLVED

The Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§8901-8913. The entire Federal Employees Health Benefits Act ("FEHBA") is re-printed in Appendix "D," attached hereto.

STATEMENT OF THE CASE

Petitioner initiated this action in the Superior Court for the State of California, County of San Diego, alleging, *inter alia*, that respondents PRUDENTIAL INSURANCE COMPANY OF AMERICA ("PRUDENTIAL") and NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES ("NLP")[1] tortiously breached the insuring provisions of the POSTMASTERS BENEFIT PLAN (the "PLAN"), an "employee organization" medical insurance plan issued by NLP and underwritten by PRUDENTIAL. Petitioner alleged, *inter alia*, that NLP and PRUDENTIAL conspired to unreasonably deny health insurance benefits to petitioner, payment of which had been requested by the UNITED STATES OFFICE OF PERSONNEL MANAGEMENT ("OPM") pursuant to the administrative liberalization provisions of FEHBA. OPM's request was based upon its findings that payment of said benefits was in the best interests of the United States government, federal employees, and the carriers themselves. In addition, petitioner's complaint set forth separate and distinct allegations of nonpayment and delays in payment of other separate and unrelated claims.

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[1] The NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES is a nonprofit corporation principally conducting business as a "carrier" under the Federal Employees Health Benefits program.

On April 15, 1984, NLP petitioned for removal to the United States District Court for the Southern District of California alleging jurisdiction under 28 U.S.C. §§1331, 1332(a) and 1441, on the grounds of: (1) complete diversity of citizenship; and (2) federal question jurisdiction. NLP's petition alleged that the POSTMASTERS BENEFIT PLAN is a government procurement contract governed by federal law, and the district court had original jurisdiction over petitioner's action because petitioner's state law claims were preempted pursuant to 5 U.S.C. §§8912 and 8902(m)(1).

Respondents PRUDENTIAL and NLP subsequently moved for summary judgment seeking an order dismissing petitioner's state law claims on the grounds that said claims were preempted by §8902(m)(1) of FEHBA. The district court granted respondents' motion, and petitioner filed a timely appeal to the Ninth Circuit Court of Appeals.[2]

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[2] As set forth at pp. 10-13, *infra*, prior to petitioner initiating his state court action, NLP had filed a declaratory relief action in the United States District Court for the Southern District of California naming OPM as a defendant and seeking a judicial declaration that respondents could lawfully disregard OPM's findings and requests made pursuant thereto. Thereafter, based upon NLP's filing of a NOTICE OF RELATED CASE, petitioner's action was consolidated with the action brought by NLP against OPM, and both cases were heard by the Honorable Leland C. Nielsen, District Judge.

Thereafter, on motions for summary judgment, the district court found against OPM in the declaratory relief action initiated by NLP, and dismissed petitioner's action as being preempted by FEHBA. Both actions were subsequently appealed to the Ninth Circuit Court of Appeals. Due to the related nature of the two actions, separate and complete records were not prepared for each action presented to the Ninth Circuit of Appeals. Thus, facts set forth in the instant petition are supported by the excerpts of record submitted in both consolidated cases, *National League of Postmasters of the United States v. United States of Personnel Management, et al.*, District Court Case No. 84-

A. Overview Of FEHBA.

In 1959, Congress enacted the Federal Employees Health Benefits Act, 5 U.S.C. §8901, *et seq.*, which created a subsidized health insurance system for federal employees. The government's subsidy is set at 60% of the average subscription costs of the six largest plans. 5 U.S.C. §8906. Employees pay the balance of the premiums due on the particular plan they select.

Congress expressly enacted FEHBA to provide "a measure of protection for civilian government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents . . . ." 1959 *U.S. Code Cong. & Ad. News*, legislative history, 2914. At the time FEHBA was enacted, Congress recognized that "a wide gap" existed between the Government, in its capacity of employer, and employers in private enterprise, with respect to health benefits for employees. *Id.* at 2914. Thus, FEHBA was designed to close the gap between health insurance benefits available in the private sector and those available to federal employees, therefore making the federal government more competitive in the recruitment and retention of competent civilian personnel. *Id.* at 2914.

FEHBA is designed to be competitive, with numerous private insurance carriers acting as underwriters. Insurers may offer four types of coverage including: (1) a government-wide "service benefit plan"; (2) a government-wide "indemnity benefit plan"; (3) "employee organization

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0341 LCN, Court of Appeal Case No. 85-5528, and *Kip Hayes v. Prudential Insurance Company of America, et al.*, District Court Case No. 84-1245, Court of Appeal Case No. 85-5527.

plans"; and (4) "comprehensive medical plans." 5 U.S.C. §8903. The instant action involves an "employee organization plan" with NLP acting as the "carrier" and PRUDENTIAL acting as the "underwriter."

The UNITED STATES OFFICE OF PERSONNEL MANAGEMENT ("OPM") is responsible, under FEHBA §8902(a), for negotiating and approving the terms of "employee organization plans" such as the one offered by respondents. The benefits under all FEHBA contracts are subject to "such maximums, limitations [and] exclusions . . . as [OPM] considers necessary or desirable." 5 U.S.C. §8902(d). OPM assumes the obligation of considering costs to federal employees and the government in approving and/or modifying health benefit plans. FEHBA specifically delegates administrative responsibilities to OPM to ensure maximum health benefits for federal employees at the lowest possible cost to the employees and the United States government. *Doe v. Divine*, 703 F.2d 1319 (D.C. Cir. 1983).

Essentially, OPM, as the governmental agency authorized to administer public funds on behalf of FEHBA plan participants, is charged with the duty of performing that function in the best interest of both the employees and the United States government.[3]

FEHBA confers express authority upon OPM to attain the goals and objectives underlying the act. 5 U.S.C. §8909(b)(2) provides that OPM shall set aside a fund "not to exceed 3% of the contributions toward the plan, determined by the Office to be reasonably adequate to

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[3] In *Doe v. Divine*, 703 F.2d 1319 (D.C. Cir. 1983), and *National Federation of Federal Employees v. Divine*, 679 F.2d 907 (D.C. Cir. 1981), the United States Court of Appeals, District of Columbia Circuit, provides a more complete "overview of FEHBA," as well as an in-depth analysis of OPM's duties with respect to the administration of the FEHBA program.

provide a contingency reserve." 5 U.S.C. §8909(b)(2) further provides that "the contingency reserves may be used . . . to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine."

5 U.S.C. §8913 provides OPM with authority to prescribe regulations necessary to carry out the provisions of the act. Pursuant to that legislative directive, OPM has promulgated regulations set forth in 5 C.F.R. §890. Section 890.503(c)(5) of OPM's regulations provides:

> In addition to those amounts, if any, paid under the above subparagraphs of this paragraph, OPM may authorize such other payments from the contingency reserve as, in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program.

B. Petitioner's Claim For Nursing Care Benefits.

Petitioner is eligible for coverage under the PLAN as a dependent of his father, a retired federal employee and member of the PLAN. Petitioner's coverage became effective under the PLAN on January 1, 1982.

Since 1974, petitioner has been a respirator-dependent quadriplegic as a result of a spinal cord injury sustained in a high school football game. Petitioner's spinal cord injury was so severe that he was hospitalized for two years and was released from the hospital only upon condition that he receive 24-hour private duty nursing care. During calendar years 1982 and 1983, petitioner received approximately $170,000 per year in private duty nursing care insurance benefits under the PLAN. It is undisputed that if petitioner did not receive these nursing care benefits, the only mode of care compatible with continued preservation of his life

would be confinement in an acute hospital care facility. It is also undisputed that acute hospital care would cost the PLAN approximately twice as much as the 24-hour nursing care.

Effective January 1, 1983, the PLAN was modified to limit private duty nursing care benefits to a maximum of $10,000 per year.[4] Hospitalization benefits, however, remained unlimited.

C. Pursuant To The Request And Direction Of OPM, The PLAN Was Liberalized In 1983 To Provide Petitioner With Unlimited Private Duty Nursing Care Benefits From The Plan's Contingency Reserve Fund Based Upon OPM's Determination That Said Payments Were In The Best Interest Of The Plan.

Recognizing its duty to preserve and further the economic interests of the United States government, the PLAN, and federal employees, OPM engaged in a comprehensive investigation and analysis aimed at determining whether or not implementation of the $10,000 nursing care limitation would be cost-effective as to petitioner. OPM's investigation included consideration of specific economic and technical factors including, but not limited to:

a. A detailed examination of the specific nursing care provided to petitioner and the extent to which said nursing care was medically necessary;

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[4] The terms of the NLP PLAN are renegotiated each year. In 1982, the PLAN provided "unlimited" benefits for private duty nursing care.

b. A determination as to whether alternative care was available through local or state government medical care programs;

c. The cost of alternative care in an acute hospital confinement facility; and

d. The extent to which confinement in an acute hospital care facility would endanger petitioner's health and interfere with the continued enjoyment of his life.

Based upon their investigation, OPM determined that petitioner would be contractually entitled to receive acute hospital confinement care benefits and that those benefits would cost the United States government, the PLAN, and federal employees approximately *twice* as much as continued payment of nursing care benefits.

Based upon OPM's determination that hospital confinement benefits would cost the PLAN twice as much as nursing care benefits, OPM requested and directed NLP to remove the $10,000 limitation for private duty nursing care from the PLAN for contract year 1983. On January 6, 1983, after considering the request and direction from OPM, NLP's board of directors[5] agreed to liberalize the PLAN and remove the $10,000 nursing care limitation as to petitioner, on condition that OPM authorize a special contingency reserve payment to NLP pursuant to OPM's authority under 5 C.F.R. 890.503(c)(5).

Thus, petitioner received unlimited nursing care benefits during calendar year 1983.[6] Thereafter, the $10,000 limitation on private duty nursing care benefits remained in

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[5] It is undisputed that the only individuals with authority at NLP or PRUDENTIAL to approve OPM's request, was the NLP Board of Directors.

[6] Respondents were reimbursed for these payments from the PLAN's contingency reserve fund.

the PLAN for calendar year 1984, and OPM once again requested that NLP remove the $10,000 limitation as to petitioner, based upon the aforementioned specific economic considerations which had remained unchanged.

D. NLP And PRUDENTIAL Refused To Comply With OPM's Request To Provide Petitioner With Unlimited Private Duty Nursing Care Benefits For Calendar Year 1984, Despite OPM's Determination That Said Payments Were In The Best Interests Of The PLAN, The United States Government, And Federal Employees.

On September 28, 1983, while negotiations were being conducted between OPM and NLP regarding the terms of the 1984 PLAN, Kevin J. Burns, Assistant Director of Insurance Programs at OPM, telephoned Mr. Keith Micheli, PLAN Administrator at NLP,[7] to request that NLP renew its agreement to provide petitioner with unlimited private duty nursing care benefits for contract year 1984. Mr. Micheli thereafter informed NLP's President, R. Fain Hambright, of Mr. Burns' request in a memo dated September 28, 1983.

On October 27, 1983, Mr. Burns wrote directly to NLP's President, Mr. Hambright, informing him that OPM had determined that it would be in the best interests of the FEHBA program to continue providing petitioner with private duty nursing care for calendar year 1984.

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[7] Although Mr. Micheli was the PLAN administrator for NLP, he was also a full-time paid employee of PRUDENTIAL. Mr. Micheli's dual capacity with NLP and PRUDENTIAL reflects the true nature of the identity of interests between NLP and PRUDENTIAL.

On November 15, 1983, approximately two and one-half months before the NLP Board of Directors voted on whether or not to accede to OPM's request to provide petitioner with unlimited private duty nursing care benefits for 1984, Mr. Ken Michler, Senior Claim Consultant at PRUDENTIAL, informed all PRUDENTIAL claims individuals involved with the NLP PLAN, that petitioner would not receive private duty nursing care benefits in excess of $10,000 for calendar year 1984.

Despite PRUDENTIAL's pre-determination that petitioner would not receive nursing care benefits in excess of $10,000, on December 29, 1983, OPM advised petitioner that OPM had not withdrawn its request that NLP provide petitioner with unlimited nursing care benefits for contract year 1984.

On February 6, 1984, the NLP Board of Directors met. Although no one from OPM was present, PRUDENTIAL's Vice-President, John Adelham, and employees Keith Micheli, and C. L. Fritz attended the meeting. During the meeting, Mr. Harvey Moritz, Vice-President of NLP, moved to liberalize the 1984 PLAN and provide petitioner with unlimited nursing care benefits to the same extent those benefits were provided during calendar year 1983, *on condition that OPM approve a modification of the 1984 PLAN*. The NLP Board of Directors were never advised that OPM had already requested such a modification! This was despite the presence of PRUDENTIAL employee Keith Micheli, and NLP President, Fain Hambright, both of whom had personally received communications from OPM indicating such a request.

Mr. Moritz' motion failed, on a five-to-four vote.[8] After the motion failed, another NLP Board member, Mr.

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[8] The NLP Board of Directors consists of nine members.

Victoria, moved to initiate a lawsuit against petitioner seeking a judicial declaration that the $10,000 nursing care limitation could lawfully be enforced against petitioner for 1984.

Thereafter, on February 13, 1984, NLP filed a declaratory relief action in the United States District Court for the Southern District of California, seeking a judicial declaration that the $10,000 nursing care limitation could be lawfully enforced against petitioner. This action was filed despite OPM's uncontradicted determination that providing petitioner with unlimited nursing care benefits from the PLAN's contingency reserve fund was in the best interests of the PLAN, the Federal Government, and Federal employees.[9]

In the declaratory relief action, NLP, as the only plaintiff, named as defendants only OPM and petitioner's father, Nobel Hayes. NLP then brought a motion for summary judgment seeking a judicial declaration that NLP was not obligated to pay claims for benefits in excess of $10,000 for private duty nursing care services rendered to petitioner during calendar year 1984.

Thereafter, petitioner moved, pursuant to Rule 19 of the Federal Rules of Civil Procedure, that he be joined as a defendant in the declaratory relief action brought by NLP

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[9] Petitioner has been able to discern only a single motive for NLP and PRUDENTIAL's refusal to comply with OPM's request. Under the FEHBA program, carriers have a financial incentive to pay, not deny, claims, because the allocation of administrative expense funds is determined on an historical claims-paid basis. (Oversight hearing on the Federal Employee Health Benefits Program—Health Care Costs: Hearings Before the Subcomm. on Compensation and Employee Benefits of the Com. on Post Office and Civil Service, 95th Cong., 1st Sess., p. 11, 55-56 (1977).) Thus, NLP and PRUDENTIAL will receive a higher allocation of administrative expense funds if petitioner receives more benefits for acute hospital care than private duty nursing care.

against OPM, and submitted a memorandum of points and authorities in opposition to NLP's motion for summary judgment.[10]

The district court granted NLP's motion for summary judgment, holding that NLP was not required to provide petitioner with private duty nursing care benefits in excess of $10,000 during calendar year 1984.

Petitioner appealed the district court's ruling on NLP's declaratory relief action, arguing that 5 U.S.C. §8909(b)(2) grants OPM the authority to compel a carrier's concurrence regarding expenditures from the contingency reserve fund when such actions are in the best interests of the PLAN.[11] OPM did not appeal the district court's adverse ruling but, instead, filed a brief with the Ninth Circuit Court of Appeals indicating that OPM interpreted §8909(b)(2) as requiring the carrier's voluntary assent to any liberalization of the PLAN. After considering petitioner's argument, the Ninth Circuit Court of Appeals concurred with OPM's interpretation. (819 F.2d 921 (9th Cir. 1987.))

E. Petitioner's Claims Under California State Law.

On April 16, 1984, petitioner filed his state court action in response to NLP's declaratory relief action.[12]

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[10] The district court never issued a ruling on petitioner's motion to be joined as a defendant in the action brought by NLP against OPM. The court did, however, accept for filing petitioner's points and authorities.

[11] The Ninth Circuit Court of Appeals noted that the district court did not rule on petitioner's motion to be joined as a defendant in the *NLP v. OPM* action; however, the Ninth Circuit specifically found that petitioner's appeal of the district court's order was effective. *Hayes v. Prudential*, 819 F.2d 921, 924 (9th Cir. 1987); p. B-7, *infra*.

[12] Petitioner stated the following causes of action: 1. Breach of Contract; 2. Declaratory Relief; 3. Breach of the Duty of Good Faith

Petitioner's state claims included allegations that NLP and PRUDENTIAL breached California's implied covenant of good faith and fair dealing by unreasonably refusing to comply with OPM's request.[13] *Petitioner further alleged that NLP and PRUDENTIAL delayed and failed to make benefit payments to petitioner which were separate and distinct from OPM's request for liberalization*[14]

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and Fair Dealing; 4. Breach of the Statutory Duties under California Insurance Code §790.03 (West's 1982); 5. Civil Conspiracy to Breach the Implied Covenant of Good Faith and Fair Dealing and to Violate California Insurance Code §790.03; 6. Common Law Fraud; and 7. Breach of Fiduciary Duty.

[13] Although OPM does not have authority under FEHBA to compel private insurance carriers such as NLP and PRUDENTIAL to liberalize their plans and receive payments from the contingency reserve fund, the implied covenant of good faith and fair dealing under California law provides a clear remedial mechanism for effectuating the express purposes of Congress—to provide Federal employees with the best possible medical insurance at the lowest possible cost. Under California law, the implied covenant of good faith and fair dealing "requires that neither party will do anything to injure the right of the other to receive the benefits of the agreement, and *an insurer is obligated to give the interests of the insured at least as much consideration as it gives its own interests.* [Emphasis added.] *Silberg v. California Life Insurance Co.*, 11 Cal.3d 452, 460 (1974). More recently, in *McCormick v. Sentinel Life Insurance Co.*, 153 Cal.App.3d 1030 (1984), the court pointed out that the "duty of good faith and fair dealing requires an insurer to place the interests of the insured above its own or its stockholders' interest[s] in maximizing gains and limiting disbursements." *Id.* at 1043. Clearly, NLP and PRUDENTIAL's decision to maximize their own administrative expense receipts, by refusing to comply with OPM's request designed to minimize costs to Federal employees and the government, constitutes a *per se* violation of the implied covenant of good faith and fair dealing as it exists under California law.

[14] Although it is undisputed that petitioner is entitled to additional nursing care benefits which have not been paid, the Ninth Circuit's decision precludes petitioner from bringing an action under California law to compel payment, while at the same time, FEHBA does not

As set forth above, the district court ultimately dismissed plaintiff's state court causes of action, holding they were preempted by §8902(m)(1) of FEHBA. The district court's order was affirmed by the Ninth Circuit Court of Appeals, giving rise to the instant Petition for Certiorari.

REASONS FOR GRANTING THE WRIT

I

THE NINTH CIRCUIT'S DECISION THAT PETITIONER'S STATE LAW CAUSES OF ACTION ARE "PREEMPTED" BY §8902 (m)(1) IS IN DIRECT CONFLICT WITH A DECISION FROM THE TENTH CIRCUIT COURT OF APPEALS

In his briefs to the Ninth Circuit Court of Appeals, petitioner, citing substantial legislative history, argued that §8902(m)(1) was intended by Congress to be a statute of "limited preemption" not intended to displace *and* supplant all state law regulating insurers under FEHBA. Petitioner further relied upon the holding in *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984) in support of his argument that FEHBA, in and of itself, does not provide FEHBA participants with a sufficient remedy to enforce individual claims for payment of benefits.

In holding that petitioner's state law claims were completely preempted by §8902(m)(1), the Ninth Circuit acknowledged that its decision was not in agreement with the Tenth Circuit's holding in *Howard. Hayes*, 819 F.2d at

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provide any remedial mechanism to compel the carriers to pay. (See discussion of *Howard v. Group Hosp. Service*, 739 F.2d 1508 (10th Cir. 1984) at pp. 15-20, *infra*.)

926, p. B-12, *infra*. Instead, the Ninth Circuit, without discussing the legislative history of §8902(m)(1) or its own decision that OPM was powerless to require respondents to act in the best interests of federal employees and the PLAN, cited such cases as *Blue Cross and Blue Shield of Florida, Inc. v. Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986), *Myers v. United States*, 767 F.2d 1072 (4th Cir. 1985), and *Tackitt v. Prudential Insurance Co.*, 758 F.2d 1572 (11th Cir. 1985), none of which address the legislative history of §8902(m)(1) or the distinct lack of remedies available to FEHBA plan participants under federal law.

The Ninth Circuit does not take issue with the Tenth Circuit's reasoning in *Howard*, nor does the Ninth Circuit's opinion address 5 C.F.R. §890.107, relied upon by the Tenth Circuit in support of its conclusion that claims for recovery under FEHBA plans should not involve the federal government, but should be individual actions brought directly against the health benefit insurers. *Howard*, 739 F.2d at 1511.

Unlike the cases interpreting §8902(m)(1) relied upon by the Ninth Circuit in its opinion below, the *Howard* court sets forth a thoughtful and well-reasoned basis for concluding that §8902(m)(1) does not preempt state law actions for recovery on individual claims under FEHBA insurance plans.

In *Howard*, the Tenth Circuit pointed out that FEHBA does not contain a procedural mechanism designed to provide a means of adjudicating individual claims:

> There is no adversarial process set up within the OPM to litigate these claims. Under 5 C.F.R. §890.105(b), the carrier initially determines whether a claim is covered under the policy, and if a claim is denied, 5 C.F.R. §890.106(c) permits a

claimant to 'make a written request to OPM's Associate Director for Compensation for a review to determine whether the plan's denial is in accord with the terms of OPM's contract with the carrier of the plan,' and 5 USC §8902(j) permits the OPM to require the carrier to pay. This review procedure apparently is designed to permit OPM to resolve major conflicts between itself and the carrier over interpretation of the plan. The regulations specifically declare that 'OPM does not adjudicate individual claims for payment or service under health benefit plans.' 5 C.F.R. §890.105(a). Under a section titled, 'Legal Actions' the implementing regulations for the FEP program state, 'An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan.' 5 C.F.R. §890.107.[15] *This contemplates that claims for recovery under the plans should not involve the*

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[15] At the time *Howard* was decided, 5 C.F.R. §890.107 provided:

> An action to compel enrollment of an employee or annuitant not excluded by §890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations or a decision made by OPM should be brought against the Office of Personnel Management, Washington, D.C. 20415.

After *Howard* was decided OPM amended §890.107 to further clarify what type of actions *must* be brought against the carrier. §890.107 was amended, May 21, 1986, to add the following:

> However, an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

> *federal government, but should be individual actions against the health benefit carrier.* (Emphasis added.)

Id. at 1511.

The *Howard* court went on to cite with approval, *Director, Edward J. Meyer Memorial Hospital v. Stetz*, 433 F.Supp. 323 (W.D.N.Y. 1977). In *Stetz*, the Civil Service Commission (now OPM) expressed its desire not to be involved in the adjudication of claims for individual benefits.[16] Basing its decision upon OPM's express desire not to be involved in the adjudication of individual claims, the *Stetz* court specifically found that actions to enforce individual claims under FEHBA programs are specifically authorized *only* against the carrier. *Id.* at 325. The court thereafter remanded the action to state court, concluding that federal question jurisdiction did not exist, and finding that "the *sole* recourse for the Stetzes is against the carrier under the statutory scheme." *Id.* at 326 (Emphasis added).

The *Howard* court, after reviewing the decisions in *Clearfield Trust Co. v. United States*, 318 U.S. 363, 63 S.Ct. 573, 87 L.Ed. 838 (1943) and *Miree v. DeKalb County*, 433 U.S. 25, 97 S.Ct. 2490, 53 L.Ed.2d 557 (1977), decided that

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[16] The Civil Service Commission, predecessor to OPM, has long recognized that the states have authority to regulate and tax FEHBA insurance carriers. The Civil Service Commission and OPM have always taken the position that FEHBA was not designed to regulate the insurance business or to override any state regulatory scheme and that no legal basis existed for it to issue a regulation restricting the applicability of state law to FEHBA contracts. For example, the Deputy General Counsel for the Civil Service Commission reported to a U. S. House Subcommittee: "It is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact that they are administering a federal contract is no reason for circumventing compliance with applicable state laws." Report of the Comptroller General of the United States, MWD 76-49, p. 16, October 17, 1975.

various state court adjudications of individual FEHBA benefit claims would not frustrate the operation of the act or conflict with any specific national policy. *Howard*, 739 F.2d at 1509-1511.

The Tenth Circuit's reasoning in *Howard* is equally, if not more, applicable to the facts of the instant case. Without the application of state law in the instant case, petitioner, OPM, and all federal FEHBA plan participants would be left without any remedial scheme that could effectuate the express Congressional purpose of providing federal employees with medical insurance benefits at the lowest possible cost to the government and to the employees. Application of California state law to petitioner's individual claim for benefits will not frustrate the operation of FEHBA, but will assist in accomplishing the express purposes of the Act.

Finally, the *Howard* court, citing *Railsback v. United States*, 181 F.Supp. 765 (D.Neb.1960), specifically held that individual claims for benefits under FEHBA are purely private controversies in which the federal government simply does not have an interest sufficient to justify invoking federal question jurisdiction. *Howard*, 739 F.2d. at 512. *Railsback* involved a claim brought under a federal group life insurance policy negotiated by the Civil Service Commission (now OPM), a situation not unlike that presented by the instant action. The Tenth Circuit agreed with the following passage from *Railsback*:

> In negotiating for and procuring a policy of group life insurance for its employees, the United States government acts as an agent and not as the insurer. There is no policy of insurance between the government and the employee. It is clear from a reading of the Act that an employee is insured under a policy purchased by the Civil Service Commission, and not under any contract with or

> obligation of the United States. The decedent here was insured under a policy with Metropolitan.
>
> * * *
>
> Under the facts in this case and the Act in question, this Court concludes that the plaintiff has no claim against the United States upon which relief can be granted, and that the United States has not consented to a suit against itself for the claim here made.
>
> The plaintiff here is not without remedy. She may yet proceed in the State Courts in order that her claim might be litigated. There is, however, no jurisdiction in this or any other federal court upon her claim.

Howard, 739 F.2d at 1512, quoting *Railsback v. United States*, 181 F.Supp. 765, 766-67 (D. Neb. 1960).

The Ninth Circuit's decision in the instant action is directly in conflict with the thoughtful and well-reasoned decision of the Tenth Circuit in *Howard*. As *Howard* indicates, federal employees have no remedy for the adjudication of individual claims under FEHBA and, in fact, OPM's implementing regulations require that individual claims for recovery of benefits be brought directly against the insurance carriers. This court's plenary consideration of the instant action is essential in order to provide clarification to the millions of federal employees insured under FEHBA benefit plans.

II

THE NINTH CIRCUIT'S OPINION IS WHOLLY CONTRARY TO PRINCIPLES OF PREEMPTION ESTABLISHED BY THIS COURT

In a recent line of cases, ending with *Pilot Life Insurance Co. v. Dedeaux*, ___ U.S. ___ , 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), this court has made it clear that areas of state law traditionally left to regulation by the states are not preempted by federal law unless the federal law both displaces *and* supplants state law—that is, when the federal law provides a superseding remedy replacing and preempting state law. This court has long held that "whether a certain state action is pre-empted is one of congressional intent. 'The purpose of Congress is the ultimate touchstone.' " *Pilot Life Ins. Co. v. Dedeaux*, at ___ U.S. ___ , 107 S.Ct. 1549, 1552 (1987) citing *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208, 105 S.Ct. 1904, 1909, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504, 98 S.Ct. 1185, 1189, 55 L.Ed.2d 443 (1978), quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103, 84 S.Ct. 219, 222, 11 L.Ed. 179 (1963).

Congress has not explicitly stated to what extent §8902(m)(1) is intended to preempt state law.[17] Thus, the

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[17] Petitioner contends that both the specific wording of §8902(m)(1) and the legislative history which preceded its enactment in 1978, make it clear that the provision was never intended to supersede State Laws regulating insurance companies. By its terms, §8902(m)(1) preempts only state laws regarding *coverage or benefits* and then only state laws which are *inconsistent* with the contractual provisions of the FEHBA plan. It does not address petitioner's action against respondents for their wrongful conduct in unreasonably refusing OPM's request to provide benefits. In addition, there is no conflict between §8902(m)(1) and the

courts must sustain petitioner's state action "unless it conflicts with federal law or would frustrate the federal scheme, or unless the courts discern from the totality of the circumstances that Congress sought to occupy the field to the exclusion of the States." *Allis-Chalmers v. Lueck*, 471

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state remedies sought by petitioner.

The legislative history of §8902(m)(1) was enacted after Congress received a report by the Comptroller General of the United States on October 17, 1975. (Report of the Comptroller General of the United States, MWD 76-49, p. 16, October 17, 1975.) The report is entitled, "Conflicts Between State Health Insurance Requirements And Contracts Of The Federal Employee Health Benefits Carriers." This report specifically addresses difficulties arising from state laws requiring medical insurance carriers to provide certain types of benefits. Likewise, a thorough examination of the Senate and House Reports in hearings before Senate and House Subcommittees reveals no mention of any intent by Congress that FEHBA supersede the McCarran-Ferguson Act and preempt all state laws regulating the business of insurance. In fact, even the titles of the bill as they changed going in and out of House and Senate Subcommittees make it clear that Congress intended only a very limited preemption. The 1978 amendment adding §8902(m)(1) was initially recorded by the Congressional Record to read: "an act to amend Chapter 89 of Title 5 of the United States Code to establish uniformity in federal employee health benefits and coverage by preempting state or local laws pertinent to such benefits and coverage which are inconsistent with such contracts." (Congressional Record, Volume 123, part 16, p. 19780 (95th Cong., 1st Sess., June 20, 1977).) The title was thereafter changed to read, "An Act to amend chapter 890 of title 5 of the United States Code to estabish uniformity in federal employee health benefits and coverage by preempting *certain* inconsistent State and local laws which are inconsistent with such contract." (emphasis added.) (Congressional Record, Volume 124, Part 12, p. 16243 (95th Cong., 2nd Sess., June 5, 1978).)

It is inconceivable that Congress intended 5 U.S.C. §8902(m)(1) to entirely emasculate the McCarran-Ferguson Act (15 U.S.C. §1011, *et seq.*) without ever mentioning it, or indeed, without enacting specific federal law designed to supplant state laws currently regulating the business of insurance.

U.S. 202, 209, 105 S.Ct. 1904, 1910, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. at 504, 98 S.Ct. at 1190.

This Court has repeatedly underscored the need to fully analyze legislative intent with respect to the preemption issue. In *Cort v. Ash*, 422 U.S. 66, 78, 45 L.Ed.2d 26, 36, 95 S.Ct. 2080 (1975), this Court set forth the following four-factored analysis to be used in determining whether state law is preempted:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff 'one of the class for whose *especial* benefit the statute was enacted,' *Texas & Pacific R. Co. v. Rigsby*, 241 U.S. 33, 39, 60 L.Ed 874, 36 S.Ct. 482 (1916) (emphasis supplied)—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? See, e.g., *National Railroad Passenger Corp. v. National Assn. of Railroad Passengers*, 414 U.S. 453, 458, 460, 38 L.Ed.2d 646, 94 S.Ct. 690 (1974) (Amtrak). Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? See, e.g., *Amtrak, supra; Securities Investor Protection Corp. v. Barbour*, 421 U.S. 412, 423, 44 L.Ed.2d 263, 95 S.Ct. 1733 (1975); *Calhoon v. Harvey*, 379 U.S. 134, 13 L.Ed.2d 190, 85 S.Ct. 292 (1964). And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law? See *Wheeldin v.*

> *Wheeler*, 373 U.S. 647, 652, 10 L.Ed.2d 605, 83 S.Ct. 1441 (1963); cf. *J. I. Case Co. v. Borak*, 377 U.S. 426, 434, 12 L.Ed.2d 423, 84 S.Ct. 1555 (1964); *Bivens v. Six Unknown Federal Narcotics Agents*, 403 U.S. 388, 394-395, 29 L.Ed.2d 619, 91 S.Ct. 1999 (1971); *id.* at 400, 29 L.Ed.2d 619, 91 S.Ct. 1999 (Harlan, J., concurring in judgment).

422 U.S at 78-79.

Applying this four-factor analysis to FEHBA, the only reasonable conclusion is that Congress did not intend that FEHBA preempt petitioner's state law created causes of action. First, FEHBA obviously creates a right in favor of petitioner. Second, there is nothing in FEHBA, or the legislative history of FEHBA, that indicates Congress intended to create a comprehensive civil enforcement mechanism designed to replace and supplant state laws regulating FEHBA insurers. To the contrary, the legislative history establishes that Congress intended §8902(m)(1) to be a statute of "limited" preemption." Third, it would be inconsistent with the underlying purposes of FEHBA to allow respondents to go unregulated and, therefore, expose thousands of federal employees to the unilateral, self-serving decisions of FEHBA insurers in conscious disregard of the welfare of the United States government and federal employees. Finally, the business of insurance has traditionally been regulated by state law. *See* W. Shernoff, S. Gage, & H. Levine, *INSURANCE BAD FAITH LITIGATION*, §§6.01-6.02[6].

Most recently, this Court addressed the preemption issue as it applies to the Employees Retirement Security Act of 1974, 29 U.S.C. §§1001, *et seq.* (ERISA) in *Pilot Life Insurance Co. v. Dedeaux*, ___ U.S. ___, 107 S.Ct. 1549 (1987). In *Pilot Life*, the Court set forth a detailed analysis

of the legislative history of §502(a) of ERISA,[18] finding that Congress intended that §502 be the exclusive remedy for all ERISA plan participants, to the exclusion of any and all state laws. *Id.* __ U.S. at __ , 107 S.Ct. at 1558. This court found that Congress' enactment of a detailed civil enforcement scheme under ERISA clearly reflects Congress' intent that ERISA's civil enforcement scheme be exclusive:

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[18] Section 502(a), as set forth in 29 U.S.C. §1132(a) provides:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, [concerning requests to the administrator for information]; or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants];

(5) except as otherwise provided in subsection (b) of this subsection, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

The civil enforcement scheme of §502(a) is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement scheme is sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan. . . . Under the civil enforcement provisions of §502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. §§502(a)(2), 409. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party. §502(g). . . .

In sum, the detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in

> §502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

107 S.Ct. at 1555-1556.

FEHBA, unlike ERISA, does not contain a detailed and comprehensive civil enforcement mechanism. Therefore, petitioner's state law causes of action should not, and *cannot* be preempted by any civil enforcement mechanisms in FEHBA. Certainly, if petitioner had an opportunity to avail himself of a comprehensive civil enforcement scheme, such as the one set forth in §502(a) of ERISA, preemption would appropriately apply to petitioner's state law causes of action. However, a holding that FEHBA preempts state-created remedies deprives petitioner and all federal employees of any remedy to enforce their rights under FEHBA programs.

In the instant action, the Ninth Circuit incorrectly relied upon *Pilot Life*, in holding that petitioner's state causes of action are preempted by FEHBA. In making this determination, the Ninth Circuit clearly violated the well-established principles of preemption set forth by this court in cases such as *Pilot Life*, *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), *Allis Chalmers Corp. v. Lueck*, 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed. 206 (1985), and *Cort v. Ash*, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975).

III

THE NINTH CIRCUIT'S FINDING OF PREEMPTION IS IN DIRECT CONFLICT WITH OPINIONS ISSUED BY CALIFORNIA COURTS AND RAISES IMPORTANT ISSUES CONCERNING THE RIGHTS OF STATES TO REGULATE THE BUSINESS OF INSURANCE

In *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), the court specifically found that §8902(m)(1) provides "limited preemption" and does not preclude recovery by FEHBA plan participants against FEHBA insurers based upon California law. *Id.* at 589, 209 Cal.Rptr. at 793. The California Court of Appeals pointed out that counsel for Blue Shield, a FEHBA insurer, "was unable to cite any federal law which would preclude recovery by Dr. Fields on the state action." *Id.*

The California decision in *Fields* is not surprising given the history of state primacy in the field of insurance. In 1945, Congress reestablished the national policy of state primacy in the regulation of insurance by enacting the McCarran-Ferguson Act, 15 U.S.C. §§1012, *et seq.* The McCarran-Ferguson Act provides, in pertinent part:

> Regulation by State law: Federal law relating specifically to insurance, applicability of certain Federal laws after June 30, 1948. (a) *The business of insurance*, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted

> by any State for the purpose of regulating *the business of insurance. . . .*

15 U.S.C. §1012 (1976) (emphasis added).

In *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed. 668 (1969), this Court observed:

> The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.
>
> . . . Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply . . . . Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* [, 8 Wall. 168, 19 L.Ed. 357] held was not 'commerce.' The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement-these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'

Id. at 459-60, 89 S.Ct. at 568.

It is inconceivable that Congress intended FEHBA to supersede the McCarran-Ferguson Act and thereby totally

emasculate the rights of the states to protect and regulate the relationship between its citizens and insurers doing business within those states. The facts of this case establish that Congress did not enact a comprehensive civil enforcement scheme capable of effectuating the express purpose of FEHBA, to provide federal employees with medical insurance benefits at the lowest possible cost. Thus, the only civil enforcement scheme capable of effectuating the express purposes of FEHBA, under the facts of this case, is California state law.

The Ninth Circuit's opinion in the instant action raises serious and important issues concerning the continued rights of states to regulate the business of insurance.

CONCLUSION

For these various reasons, this petition for certiorari should be granted. Petitioner respectfully submits that Congress did not intend that FEHBA completely preempt all state laws regulating insurers under FEHBA plans. To the contrary, the legislative history of FEHBA, as well as the distinct absence of any comprehensive civil enforcement scheme designed to effectuate the express purposes of FEHBA, reflect Congress' intent that §8902(m)(1) be a statute of "limited preemption." The irreconcilable disagreement between the circuit courts on the preemption issue reflects the clear need for resolution of these issues by this Honorable Court.

DATED: November 12, 1987

Respectfully submitted,

Law Offices of
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RICK L. BOVE

APPENDIX "A"

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

FILED, JAN 22, 1985
ENTERED, JAN 23, 1985
Clerk, U.S. District Court
Southern District Of California
By S. Miller Deputy

KIP HAYES, Plaintiff, v. PRUDENTIAL INSURANCE COMPANY, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, and NOBEL A. HAYES, Defendants.	Civil No. 84-1245-N(M) ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

This matter came before this Court on January 14, 1985, for hearing on the motion for summary judgment of defendants Prudential Insurance Company and National League of Postmasters.

Plaintiff Kip Hayes appeared by Harvey R. Levine of Shernoff & Levine. Defendant Prudential Insurance Company appeared by James S. Cline of Adams, Duque & Hazeltine, and defendant National League of Postmasters appeared by John T. Kotelly of Dickstein, Shapiro & Morin. Upon consideration of the arguments of counsel and the moving and opposing papers:

IT IS HEREBY ORDERED that defendants' motion for summary judgment is granted as to all counts of the plaintiff's complaint. This Court concludes as to counts one and two of the complaint that benefits for private duty nursing care have been lawfully reduced to $10,000 per person per year in the 1984 Postmasters Benefit Plan and

that defendants are not obligated to pay claims for private duty nursing benefits in excess of this amount during 1984 nor during any year thereafter so long as the limitation remains. As to the remaining counts in plaintiff's complaint, this Court concludes that these claims under California state laws are preempted under Title V, United States Code section 8902(m)(1).

IT IS SO ORDERED.

Dated: January 22, 1985.

LELAND C. NIELSEN,
United States District Judge

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APPENDIX "B"

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KIP HAYES,
Plaintiff-Appellant,
v.
PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Defendants-Appellees.

Nos. 85-5527;
85-5528
D.C. Nos.
CV-84-1245-LCN
CV-84-0341-LCN
OPINION

Argued and Submitted
November 4, 1985—San Diego, California

Filed June 15, 1987

Before: James R. Browning, Charles Wiggins and Melvin Brunetti, Circuit Judges.

Opinion by Judge Brunetti

Appeal from the United States District Court
for the Southern District of California
Leland C. Nielsen, District Judge, Presiding

SUMMARY

Public Employees

Appeal from two summary judgments. Affirmed.

Appellant Kip Hayes (Kip) is the son of Nobel Hayes (Hayes), a retired federal employee. Kip was injured in a high

school football game and became a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of the injury Kip was covered as a family member on his father's plan issued under the FEHBA. The plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan was modified to eliminate such benefits, Hayes enrolled in another FEHBA plan during an open season enrollment period during which changes were permitted. In 1982 Hayes switched to a plan offered by the National League of Postmasters (NLP). In 1983 the NLP was formulated to place a $10,000 limit on benefits for private duty nursing care. The limit was lifted for 1983, but instituted for 1984 and future years.

In February 1984, NLP filed a declaratory relief action in district court naming the Office of Personnel Management (OPM) [which negotiated with NLP regarding the scope of coverage of the plan] and Hayes as defendants. The district court granted summary judgment in favor of NLP on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 plan. In April 1984 Kip brought an action against NLP in state court arguing that his enrollment in the 1982 plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits. The action was removed to federal district court where the court granted summary judgment in favor of the defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA.

[1] Although neither Hayes or the OPM appealed the declaratory judgment action in favor of NLP, Kip requested that he be joined as a defendant in that action and the court consolidated the two cases. Kip therefore effectively appealed from the summary judgment in the declaratory relief suit.

[2] An FEHBA provision requiring that a carrier agree to pay in an individual case if OPM finds the family member is

entitled to payment under the terms of the contract does not grant OPM authority unilaterally to alter the terms of the plan, but only requires that the carrier comply with the OPM's interpretation of the plan. OPM's consistently held view is that appellant is not entitled to unlimited benefits under the plan. [3] Appellant also urges that an FEHBA provision providing for a contingency reserve grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. But the OPM's interpretation of the provision as requiring the carrier's concurrence before contingency reserve funds may be used is entitled to substantial deference. [4] Consistent with this view the OPM never invoked authority to direct payment of the additional benefits, and appellant has not challenged OPM's interpretation of its authority. [5] Appellant also contends that the Catastrophic Protection provision of the plan allows the benefits, [6] but this provision only requires payment of 100% of eligible expenses (as opposed to 80%) in some circumstances and does not operate independent of the $10,000 limitation on private nursing care. [7] The limitation on private duty nursing care restricts the eligible expenses subject to the Catastrophic Protection provision.

[8] Appellant's contention that his state law tort and contract claims are not preempted by FEHBA because the claims relate to the manner in which the claim was processed, not to the nature or extent of coverage or benefits, draws a distinction that cannot be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. [9] Because the state law claims invariably expand obligations under the terms of the plan, the claims are inconsistent with the plan and preempted by FEHBA. This holding is supported by the Supreme Court's decision that the Employee Retirement Income Security Act preempts state common law tort and contract claims for benefits. To the extent the state law claims are predicated on an alleged obligation to provide benefits in excess of the $10,000 limit the claims are moot.

COUNSEL

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Edward R. Cohen, John T. Kotelly, Ira Mitzner and Elaine Metlin, Washington, D.C.; James S. Cline, Los Angeles, California; R. J. Coughlin, Jr., San Diego, California, for the defendants-appellees.

Phillip S. Neal, Washington, D.C.; James R. Barnett, Washington, D.C., for the amicus curiae.

OPINION

BRUNETTI, Circuit Judge:

This is an appeal from summary judgments granted in two consolidated cases. *Kip Hayes v. Prudential Insurance Co.*, No. 85-5527 (D.C. No. 84-1245), and *National League of Postmasters of the United States v. United States Office of Personnel Management and Nobel Hayes*, No. 85-5528 (D.C. No. 84-0341). We are asked to review the district court's rulings that federal employee health benefits lawfully may be reduced from year to year, and that the Federal Employee Health Benefits Act preempts state law tort and contract actions.

Though we are moved by the compelling circumstances surrounding Kip Hayes and his family, we find that the statute and health benefits plan we are called upon to construe require an unmistakable result. Until Congress acts to ensure continued coverage for federal enrollees who require long-term care, this court will be powerless to provide appellant with the remedy he seeks.

We affirm the district court.

I. THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT

The Federal Employee Health Benefits Act (FEHBA) established a comprehensive program to provide federal employees and retirees with subsidized health care benefits. 5 U.S.C. §§ 8901-8913 (1982 & Supp. 1987). Under the Act, the United States does not act as an insurer, but, through the Office of Personnel Management (OPM), contracts with various private carriers to develop health care plans with varying coverages and costs. The plans are for a term of one year, and are renegotiated annually.

After OPM negotiates changes with the carriers all federal enrollees are permitted to switch enrollment from one plan to another, regardless of their state of health, during a period called "open season." Each enrollee thus may obtain the most beneficial plan but is not guaranteed the same coverage in future years that had been available the preceding year.

The National League of Postmasters (NLP or Postmasters) is a nonprofit corporation and a carrier under FEHBA. Each year, OPM and Postmasters negotiate a contract that determines the benefits Postmasters will provide that year to enrollees in the Postmasters Health Benefits Plan (Plan). The contract between OPM and Postmasters sets forth the precise terms of coverage under the Plan. OPM then issues a Postmasters Benefit Brochure (Brochure) which provides a complete description of the benefits available to enrollees that year.

For several years, Prudential Insurance Company of America (Prudential) has entered into agreements with Postmasters whereby Prudential issues an annual policy to Postmasters which incorporates the terms and conditions of the Brochure as negotiated by Postmasters and OPM for the year. Pursuant to the policy, Prudential administers certain claims presented to Postmasters for payment and, in effect,

guarantees that Postmasters can pay the benefits due enrollees under the Plan.

II. FACTS AND PROCEEDINGS

Appellant Kip Hayes is the son of Nobel Hayes, a retired federal employee. Appellant was injured in a high school football game in November 1976, and was rendered a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of his injury, appellant was covered as a family member under a FEHBA plan in which his father was enrolled. This plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan later was modified to eliminate private duty nursing care benefits, Nobel Hayes enrolled during open season in another FEHBA plan that did provide unlimited benefits for private duty nursing care. By 1982, Nobel Hayes again had switched coverage, and enrolled in the plan offered by Postmasters, which at the time had no limits on benefits for private duty nursing care.

In October 1982, following negotiations between OPM and Postmasters, the 1983 Postmasters Plan was formulated to place a $10,000 limit on benefits for private duty nursing care. By subsequent agreement between OPM and Postmasters, the 1983 Plan was amended to remove the $10,000 limit.

The Postmasters Plans for 1984 and 1985 again contained a $10,000 limit on benefits for private duty nursing care. The 1984 and 1985 Plans were not amended and, through the date of the summary judgments in both cases, contained the $10,000 limitation.

In February 1984, Postmasters filed in district court a declaratory relief action naming OPM and Nobel Hayes as defendants. *NLP v. OPM*, D.C. No. CV-84-0341-LCN. Postmasters sought a declaration that private duty nursing care benefits provided under its 1982 Plan could be reduced in

subsequent policy contract years and that under its 1984 Plan Postmasters was not obligated to provide Kip Hayes with private nursing benefits in excess of $10,000.

In April 1984, appellant brought an action against Prudential and Postmasters in the Superior Court for the State of California. The action was removed to federal district court. *Hayes v. Prudential*, D.C. No. CV-84-1245-LCN. Appellant alleged that his enrollment in the 1982 Plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits, and that Postmasters and Prudential had breached the contract by refusing to provide unlimited benefits in 1984. Based on this theory of his rights under the Plan, appellant sought damages alleging various state law causes of action including breach of a duty of good faith and fair dealing, and breach of Cal. Ins. Code § 790.03 (West 1982).

The district court granted summary judgment in favor of Postmasters in *NLP v. OPM* on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 Postmasters Plan and that Postmasters accordingly was not required to pay claims in excess of that amount.

In *Hayes v. Prudential*, the court granted summary judgment in favor of defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA, 5 U.S.C. § 8902(m)(1).

III. DISCUSSION

1. *Effective Appeal.*

Postmasters and OPM contend that there has been no effective appeal from *NLP v. OPM*. The basis for this contention is that neither OPM nor Nobel Hayes, the named defen-

dants, have appealed, and the appeal by Kip Hayes is not effective because he was not a party to the action.

[1] A motions panel of this court, however, has determined that Kip Hayes' appeal in *NLP v. OPM* was effective. In his Memorandum of Points and Authorities in Opposition to Motion for Summary Judgment in the *NLP v. OPM* action, appellant requested that the district court join him as a defendant pursuant to Fed. R. Civ. P. 19. The district court treated appellant's request as a motion for consolidation with *Hayes v. Prudential*, and consolidated the cases. Consolidation by the district court led the motions panel to conclude that Kip Hayes effectively appealed from the summary judgment in *NLP v. OPM*.

2. *Standard of Review.*

We review de novo the district court's decision regarding the $10,000 limit on benefits and the preemption of state law claims. *See Darring v. Kincheloe*, 783 F.2d 874, 876, (9th Cir. 1986) (grant of summary judgment is reviewed de novo). Summary judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

3. *$10,000 Limit on Nursing Care Benefits.*

Appellant contends that the district court erred in granting summary judgment for appellees because (1) Postmasters and Prudential were required to comply with an OPM directive to provide him unlimited private duty nursing care benefits, and (2) the Plan's Catastrophic Protection provision requires Postmasters and Prudential to provide nursing care benefits without regard to the $10,000 limitation stated elsewhere in the policy.

a) *OPM Directive.*

Appellant cites two sections of FEHBA which he contends grant OPM the authority to require Postmasters and Prudential to provide him with unlimited nursing care benefits.

[2] 5 U.S.C. § 8902(j) provides that "[e]ach contract under this chapter shall require the carrier to agree to pay for or provide a health service . . . in an individual case if [OPM] finds that the . . . family member . . . is entitled thereto under the terms of the contract." This provision does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan. OPM's consistently held view is that, under the Plan's terms, appellant is *not* entitled to unlimited benefits. As a result, Postmasters and Prudential were not required, under section 8902(j), to provide appellant benefits in excess of the $10,000 limit.

Appellant also cites as support 5 U.S.C. § 8909(b)(2). That section states that OPM shall set aside not more than three percent of the payments to each FEHBA plan as a contingency reserve which may be used, among other purposes, to increase the benefits in the plan from which the reserves are derived. The contingency reserve is a resource OPM can use in negotiations with a carrier to expand plan benefits. The availability of such funds was central to the agreement between OPM and Postmasters to remove the $10,000 limit from the 1983 Plan.

[3] Appellant urges that section 8909(b)(2) grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. The provision apparently has not been construed by the courts. OPM interprets the provision as requiring the carrier's concurrence before contingency reserve funds may be used to extend benefits beyond those within the express terms of the Plan. OPM's interpretation of the provision is entitled to substantial deference, and will be upheld unless unreasonable. *See Filiberti v. Merit Sys. Protection Bd.*, 804 F.2d 1504, 1508 (9th Cir. 1986)

[4] We do not decide the nature or extent of OPM's authority under section 8909(b)(2). Consistent with its view that the carrier's concurrence was necessary, OPM never invoked

authority under the section to direct Postmasters to provide additional benefits. Appellant has not challenged OPM's interpretation of its authority under section 8909(b)(2), nor has he alleged that OPM had a duty to ensure that contingency reserve funds be used to provide him with increased benefits. OPM, in fact, was never named as a defendant in appellant's suit to obtain nursing care benefits.

Contrary to appellant's repeated assertions, the record indicates only that OPM unsuccessfully sought Postmasters' voluntary agreement to amend the 1984 contract. We find no legal or factual bases for appellant's claim that Postmasters or Prudential violated a binding OPM directive.

b) *Catastrophic Protection.*

[5] Appellant next contends that the Catastrophic Protection provision of the Plan ensures him unlimited private duty nursing care benefits. The provision, at page 20 of the Brochure, states:

> CATASTROPHIC PROTECTION
>
> Under the High Option, if, in a calendar year, the out-of-pocket expenses for coinsured eligible expenses exceed $1,000 for a person under Self Only ($2,000 per family under Self and Family) the Plan will pay 100% of the eligible expenses during the remainder of that calendar year.
>
> Expenses incurred for the treatment of mental, psychoneurotic and personality disorders are not included under the Catastrophic Protection Benefit.

[6] This provision requires Postmasters to pay 100% of eligible expenses (when out-of-pocket expenses exceed a certain amount) as opposed to 80% of such expenses it would pay in other situations. The provision does not, however, operate

independent of the $10,000 limitation on private nursing care.

[7] The operative language here is the phrase "eligible expenses." The eligible expenses for nursing care are set out immediately above the Catastrophic Protection provision:

> PRIVATE DUTY NURSING CARE BENEFIT
>
> Benefits for private duty nursing care by a professional registered nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) are limited to a maximum of $10,000 per person per calendar year.

Appellant's contention that the Catastrophic Protection provision requires Postmasters to provide unlimited private nursing care benefits renders meaningless the phrase "eligible expenses" and ignores the $10,000 limitation stated plainly on the same page of the Brochure and again on page 27. *See Garvey v. Prudential Ins. Co. of America*, 596 F. Supp. 1119, 1126 (E.D. Pa. 1984) (Catastrophic Protection provision is subject to the $10,000 limitation on benefits for private duty nursing care). We find no merit in appellant's alternative argument that the Brochure language is ambiguous and should be construed in his favor. *See Id.* at 1125-26.

4. *State Law Claims.*

The final issue before us concerns the extent to which FEHBA preempts state law. The district court granted summary judgment for appellees in *Hayes v. Prudential* on this issue on the ground that FEHBA's section 8902(m)(1) preempted appellant's state law claims.

This section reads:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or

> benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977).

The parties advance differing views concerning the extent of federal preemption under FEHBA. Appellees contend that the preemption provision is extremely broad, while appellant characterizes the provision as one of "limited preemption" which precludes only those state claims that apply to the "benefit structure" of the plan. The courts are not in agreement on this question. *Compare Blue Cross & Blue Shield of Florida, Inc. v. Department of Banking and Fin.*, 791 F.2d 1501 (11th Cir. 1986)(Florida's Unclaimed Property Act preempted to the extent it conflicts with federal employee benefit plan); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (state law which purports to allow recovery of additional benefits not contemplated by a federal insurance contract must be deemed inconsistent with and preempted by FEHBA); and *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985)("the interpretation of health insurance contracts is controlled by federal, not state, law") *with Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984) (approving state law interpretation of FEHBA Plan provisions).

[8] Appellant contends that his state law claims[1] are not

[1]Appellant alleged the following state law causes of action: (1) breach of contract, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of duties under Cal. Ins. Code § 790.03 (West 1982), (4) civil conspiracy to breach the implied covenant of good faith and fair dealing and to violate Cal. Ins. Code § 790.03 (West 1982), (5) common law fraud, and (6) breach of fiduciary duty.

preempted under section 8902(m)(1), because the claims relate to the manner in which Postmasters and Prudential *processed* his benefits, and not to the "nature or extent of coverage or benefits." No such distinction can be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-20 (1985) (state tort claim stemming from manner in which a Labor Management Relations Act insurance benefit claim was handled is not independent of insurance contract and therefore is preempted by federal law). Moreover, the claims "relate to" the plan under section 8902(m)(1) as long as they have a connection with or refer to the plan. *Blue Cross*, 791 F.2d at 1504. All appellants' state law claims refer to the plan, and therefore fall under the preemption clause.

[9] Because the state law claims invariably expand appellees' obligations under the terms of the Plan, the claims are inconsistent with the Plan and, hence, preempted under § 8902(m)(1). Our holding is supported by the Supreme Court's recent decision that the Employee Retirement Income Security Act (ERISA) preempts state common law tort and contract claims for benefits under an ERISA-regulated plan. *Pilot Life Ins. Co. v. Dedeaux*, 55 U.S.L.W. 4471 (U.S. Apr. 6, 1987)(No. 85-1043). ERISA's preemption clause is similar to section 8902(m)(1) of the FEHBA.[2] And the Court held that the state claims were preempted despite a saving clause, 29 U.S.C. § 1144(b)(2)(A), which has no counterpart in the FEHBA. Thus, we hold Hayes' state law claims are preempted by the FEHBA. We note that, to the extent the state law claims are predicated on an alleged obligation of appellees to provide benefits in excess of the $10,000 limit stated in the Plan, the claims are moot in light of our ruling that no such obligation existed.

[2]ERISA's preemption clause states that "the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a).

IV. CONCLUSION

Appellant has brought an effective appeal from the summary judgment in *NLP v. OPM*. Postmasters lawfully reduced private duty nursing care benefits to $10.000 in the 1984 and 1985 Plans, and was not required by OPM or the Catastrophic Protection provision to provide appellant with benefits in excess of that amount. Appellant's state law claims are preempted under 5 U.S.C. § 8902(m)(1). The judgment of the district court is AFFIRMED.

APPENDIX "C"

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED, JUL 21 1987
Cathy A. Catterson, Clerk
U.S. Court of Appeals

KIP HAYES,	)	CA Nos.
	)	85-5527
Plaintiff-Appellant,	)	85-5528
	)	
vs.	)	DC Nos.
	)	
PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,	)	CV-84-1245-LCN
	)	CV-84-0341-LCN
	)	
	)	ORDER
	)	
Defendants-Appellees.	)	

Before: BROWNING, WIGGINS and BRUNETTI, Circuit Judges.

Appellant's petition for rehearing is denied.

APPENDIX "D"

Federal Employees Health Benefits Act ("FEHBA") 5 U.S.C.

§ 8901. Definitions

For the purpose of this chapter--

(1) "employee" means--

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual employed by the government of the District of Columbia;

(F) an individual employed by Gallaudet College; and

(G) an individual employed by a county committee established under section 590h(b) of title 16;

but does not include--

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian

Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means--

(A) an employee who retires on an immediate annuity under subchapter III of chapter 83 of this title or another retirement system for employees of the Government, after 5 or more years of service or for disability;

(B) a member of a family who receives an immediate annuity as the survivor of an employee or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of--

(i) an employee who dies as a result of injury or illness

compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including--

(A) an adopted child or recognized natural child; and

(B) a stepchild, or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship; or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(8) "employee organization" means an association or other organization of employees which is national in scope, or in which membership is open to all

employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter, and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe; and

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant--

(A) who has not remarried before age 55 after the marriage to the

employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C)(i) who is receiving any portion of an annuity under section 8345(j) of this title or a survivor annuity under section 8341(h) of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h) or 8345(j) of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) of this title (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees, except that such term shall not include any such unremarried former spouse of a former employee whose marriage was

dissolved after the former employee's separation from the service (other than by retirement).

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier--

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 of this title and for carriers offering

the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, or former spouse whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, or former spouse who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier

except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term,

based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, or former spouse is entitled thereto under the terms of the contract.

(k) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, family member, or former spouse covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. The provisions of this subsection shall not apply to group practice prepayment plans.

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this title which any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any

regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an

individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service benefit plan.--One Government-wide plan, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, or former spouses or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, or former spouse.

(2) Indemnity benefit plan.--One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums

of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) Employee organization plans.--Employee organization plans which offer benefits of the types referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive medical plans.--

(A) Group-practice prepayment plans.--Group-practice prepayment

plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(B) Individual-practice prepayment plans.--Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid

basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

§ 8904. Types of benefits

The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) Service benefit plan.--

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(2) Indemnity benefit plans.--

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribed drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(3) Employee organization plans.--Benefits of the types named under paragraph (1) or (2) of this section or both.

(4) Comprehensive medical plans.--Benefits of the types named under paragraph (1) or (2) of this section or both.

All plans contracted for under paragraphs (1) and (2) of this section shall include benefits both for costs

associated with care in a general hospital and for other health services of a catastrophic nature. Pub.L. 89-554, Sept 6, 1966 80 Stat.603.

§ 8905. Election of coverage

(a) An employee may enroll in an approved health benefits plan described by section 8903 of this title either as an individual or for self and family.

(b) An annuitant who at the time he becomes an annuitant was enrolled in a health benefits plan under this chapter--

(1) as an employee for a period of not less than--

(A) the 5 years of service immediately before retirement;

(B) The full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management in which he is eligible to enroll in the plan and the date on which he becomes an annuitant; or

(C) the full period or periods of service beginning with the enrollment which became effective before January 1, 1965, and ending with the date on which he becomes an annuitant;

whichever is shortest; or

(2) as a member of the family of an employee or annuitant;

may continue his enrollment under the

conditions of eligibility prescribed by regulations of the Office.

(c)(1) A former spouse may--

(A) within 60 days after the dissolution of the marriage, or

(B) in the case of a former spouse of a former employee whose marriage was dissolved after the employee's retirement, within 60 days after the dissolution of the marriage or, if later, within 60 days after an election is made under section 8339(j)(3) of this title for such former spouse by the retired employee,

enroll in an approved health benefits plan described by section 8903 of this title as an individual or for self and

family as provided in paragraph (2) of this subsection, subject to an agreement to pay the full subscription charge of the enrollment, including the amounts determined by the Office to be necessary for administration and reserves pursuant to section 8909(b) of this title. The former spouse shall submit an enrollment application and make premium payments to the agency which, at the time of divorce or annulment, employed the employee to whom the former spouse was married or, in the case of a former spouse who is receiving annuity payments under section 8341(h) or 8345(j) of this

title, to the Office of Personnel Management.

(2) Coverage for self and family under this subsection shall be limited to--

(A) the former spouse; and

(B) unmarried dependent natural or adopted children of the former spouse and the employee who are--

(i) under 22 years of age; or

(ii) incapable of self-support because of mental or physical disability which existed before age 22.

(d) If an employee has a spouse who is an employee, either spouse, but not

both, may enroll for self and family, or each spouse may enroll as an individual. However, an individual may not be enrolled both as an employee or annuitant and as a member of the family.

(e) An employee, annuitant, or former spouse enrolled in a health benefits plan under this chapter may change his coverage or that of himself and members of his family by an application filed within 60 days after a change in family status or at other times and under conditions prescribed by regulations of the Office.

(f) An employee, annuitant, or former spouse may transfer his enrollment from a health benefits plan described by

section 8903 of this title to another plan described by that section at the times and under the conditions prescribed by regulations of the Office.

§ 8906. Contributions

(a) The Office of Personnel Management shall determine the average of the subscription charges in effect on the beginning date of each contract year with respect to self alone or self and family enrollments under this chapter, as applicable, for the highest level of benefits offered by--

(1) the service benefit plan;

(2) the indemnity benefit plan;

(3) the two employee organization plans with the largest number of

enrollments, as determined by the Office; and

(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Office.

(b)(1) Except as provided by paragraphs (2) and (3) of this subsection, the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 60 percent of the average subscription charge determined under subsection (a) of this section. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment

begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek

bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office)

(c) There shall be withheld from the pay of each enrolled employee and the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) the amount necessary to pay the total charge for enrollment, after the

Government contribution is deducted, shall be withheld from the pay of each enrolled employee and from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e)(1) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office. The regulations may provide for the waiving of contributions by the employee and the Government.

(2) an employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph

(1) of this subsection and implementing regulations.

(f) The Government contributions for health benefits for an employee shall be paid--

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g) The Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the

adjustment of the converted rate to the nearest cent.

§ 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by section 8903 of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the--

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

§ 8908. Coverage of restored employees and survivor annuitants

(a) An employee enrolled in a health benefits plan under this chapter who is removed or suspended without pay and later reinstated or restored to duty on the ground that the removal or suspension was unjustified or

unwarranted may, at his option, enroll as a new employee or have his coverage restored, with appropriate adjustments made in contributions and claims, to the same extent and effect as though the removal or suspension had not taken place.

(b) A surviving spouse whose survivor annuity under this title was terminated because of remarriage and is later restored may, under such regulations as the Office of Personnel Management may prescribe, enroll in a health benefits plan described by section 8903 of this title if such spouse was covered by any such plan immediately before such annuity was terminated.

§ 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available--

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) a percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of employees

and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) of this title are merged, the assets (including contingency reserves) and liabilities of

the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, or former spouse affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter.

(e) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans

continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

§ 8910. Studies, reports, and audits

(a) The Office of Personnel Management shall make a continuing study of the operation and administration of this chapter, including surveys and reports on health benefits plans available to employees and on the experience of the plans.

(b) Each contract entered into under section 8902 of this title shall contain provisions requiring carriers to--

(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter; and

(2) permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this chapter.

(c) Each Government agency shall keep such records, make such certifications, and furnish the Office with such information and reports as may be

necessary to enable the Office to carry out its functions under this chapter.

§ 8911. Advisory committee

The Director of the Office of Personnel Management shall appoint a committee composed of five members, who serve without pay, to advise the Office regarding matters of concern to employees under this chapter. Each member of the committee shall be an employee enrolled under this chapter or an elected official of an employee organization.

§ 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter.

§ 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described

by section 8903 of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude--

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been

so employed by the Board for a period or periods totalling not less than two school years; or

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the

month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.

Supreme Court, U.S.
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No. 87-818

IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

KIP HAYES,
Petitioner,
v.
PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION FOR RESPONDENT NATIONAL LEAGUE OF POSTMASTERS

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QUESTION PRESENTED

Are state law causes of action based on: (1) breach of duty of fair dealing and good faith; (2) breach of fiduciary duty; and (3) breach of statutory duties, which relate to and are inconsistent with the terms of federal contracts authorized by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8913, preempted by 5 U.S.C. § 8902(m)(1)?

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---

BRIEF IN OPPOSITION FOR RESPONDENT NATIONAL LEAGUE OF POSTMASTERS

STATUTE AND REGULATIONS INVOLVED

This case involves the Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§ 8901-8913 ("FEHBA"), and its underlying regulations, which appear at 5 C.F.R. Part 890. The FEHBA is reprinted in Petitioner's Appendix ("Pet. App.") at D1-D56. Provisions of 5 C.F.R. Part 890 cited by respondent are reprinted in the appendix hereto, p. 1a-8a, *infra.*

STATEMENT OF THE CASE

We adopt the findings of fact contained in section II of the Court of Appeals' opinion. Pet. App. at B6-7.[1]

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[1] At Pet. 14 n.14, petitioner contends that "it is undisputed that petitioner is entitled to additional nursing care benefits which have

The Statutory and Regulatory System

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8913, is a comprehensive scheme to provide federal employees, retirees ("annuitants") and covered family members with government-subsidized health care benefits. Under FEHBA, the United States Office of Personnel Management ("OPM") contracts with qualified private organizations ("carriers") to create the various types of health benefits plans described in 5 U.S.C. § 8903.[2] The contracts are for a term of one year subject to renewal and are renegotiated annually. *See* § 8902 (a); 5 C.F.R. § 890.203. Each contract contains a detailed statement of the benefits offered and includes such maximums, limitations, exclusions, and other definitions of benefits as OPM considers necessary or desirable. *See* § 8902(d).

The federal government subsidizes the health benefits plans under the formula set forth in § 8906, which provides for a government contribution of 60% of the average cost of six selected plans. *See* § 8906(b)(1). The rates charged for the health benefits plans reflect the cost of the benefits provided, and are readjusted based on past experience and benefit adjustments. *See* § 8902(i).

OPM is responsible for providing information concerning the various health benefits plans to employees and annuitants. *See* § 8907. During the annual "open season," these individuals can switch from one plan to another, regardless of their present state of health or that of their covered family members. *See* §§ 8902(f), 8905(e); 5 C.F.R. § 890.301(d).

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not been paid . . . ." Petitioner fails to identify what those benefits are. In fact, none of the claims stated in his complaint were "undisputed," and all were rejected by the Court of Appeals.

[2] Section 8903 lists four types of health benefits plans: the service benefit plan, the indemnity benefit plan, employee organization plans and comprehensive medical plans. The Postmasters Benefit Plan ("Plan") is an employee organization plan open to all eligible federal employees, annuitants and their families.

FEHBA establishes a comprehensive framework by which OPM is empowered to regulate the federal health benefits program. OPM is authorized to prescribe minimum standards for carriers and to withdraw approval of their plans if the carriers fail properly to discharge their contractual obligations. 5 U.S.C. § 8902(e); 5 C.F.R. § 890.204. Under 5 U.S.C. § 8902(j), the carrier must agree to pay for or provide a health service or supply in an individual case if OPM determines that the enrollee or family member is entitled thereto under the terms of its contract with OPM.[3] To this end, OPM has established an administrative review process that allows any subscriber who believes that a carrier has erroneously denied a claim for benefits to appeal to OPM. 5 C.F.R. § 890.105. OPM also performs routine audits of each carrier to determine whether improper claims handling practices exist. *See* 5 U.S.C. § 8910 and 5 C.F.R. § 890.202(d). See also p. 6 n.5, *infra*.

REASONS FOR DENYING REVIEW

I. The Court of Appeals Correctly Followed Controlling Decisions of this Court

The decision below correctly held that FEHBA preempts both common-law and statutory state tort actions against FEHBA carriers. This result is fully in accord with two recent preemption decisions of this Court, *Pilot Life Insurance Co.* v. *Dedeaux*, 107 S. Ct. 1549 (1987), and *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985).

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[3] Section 8902(j) "does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan." Pet. App. at B9. The Court of Appeals also upheld OPM's interpretation of § 8909(b)(2), which authorizes OPM to create a contingency reserve out of payments to a plan which can be used to expand benefits, as requiring carrier concurrence. *Id.*

FEHBA was amended in 1978 to add an express preemption provision, 5 U.S.C. § 8902(m)(1). That section provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

Petitioner argues that state tort claims based on the manner in which benefits are processed are outside the scope of § 8902(m)(1) because such claims do not pertain to coverage or benefits and do not conflict with the terms of FEHBA contracts. Pet. 21 n.17. Petitioner is wrong.

Petitioner's misunderstanding of preemption principles is best exemplified by his heavy reliance on *Cort* v. *Ash*, 422 U.S. 66 (1975). *Cort* v. *Ash* does not contain a single reference to, let alone discuss, "preemption." Instead, *Cort* sets out four factors that determine *whether a private right of action should be implied* under a statute that does not provide one expressly. 422 U.S. at 78-79. Petitioner's reliance on *Cort* can apparently be traced to *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985), which determined on the basis of a *Cort* analysis that a private right of action should not be implied under section 409(a) of ERISA, 29 U.S.C. § 1109(a). But *Russell* likewise says nothing about preemption.

Petitioner's confusion is not limited to his misuse of *Cort* v. *Ash*. He likewise misunderstands other decisions of this Court that sustain preemption under federal contracts indistinguishable from the FEHBA contract from which petitioner's claims arise.

Pilot Life Insurance Co. v. *Dedeaux*, 107 S. Ct. 1549 (1987), disposes of petitioner's claim that § 8902(m)(1) must be construed narrowly. In *Pilot Life*, this Court held that state tort claims based on improper processing of benefits were preempted under ERISA's express preemption clause, which preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

Pilot Life followed *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), and *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983), which decided that " '[t]he phrase "relate to" was given its broad common-sense meaning, such that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *See* 107 S. Ct. at 1553. *Pilot Life* held that the state tort claims in that suit related to an employee benefit plan, and were not saved from preemption by ERISA's saving clause, which excepts from preemption those state laws that "regulate insurance." *Id.* at 1553-55.[4]

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[4] To reach this conclusion, the Court examined three criteria used to determine whether a practice regulated the business of insurance for the purposes of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. Applying those criteria, the Court held that the Mississippi law of bad faith does not regulate insurance, since that law "developed from general principles of tort and contract law available in any Mississipi breach of contract case." *Id.* at 1555.

Petitioner maintains throughout his petition that Congress did not intend that FEHBA "emasculate" the rights of states to regulate the business of insurance authorized by the McCarran-Ferguson Act. To the extent that petitioner's argument rests on the premise that common-law state tort claims regulate the business of insurance, *Pilot Life* has explicitly rejected that argument. Moreover, even if the generalities of the McCarran-Ferguson Act were otherwise applicable, it is quite clear that FEHBA contracts are not *insurance* contracts. FEHBA's relationship to the McCarran-Ferguson Act is explicitly discussed in a letter written by Alan K. Campbell, then-chairman of the Civil Service Commission, to Senator Ribicoff, in which he explained why the preemption provi-

The Ninth Circuit recognized correctly that under *Pilot Life*, "Hayes' state law claims are preempted by the FEHBA." Pet. App. at B13. Not only is ERISA's preemption provision "similar to section 8902(m)(1) of the FEHBA," but "the state claims [in *Pilot Life*] were preempted despite a saving clause which has no counterpart in the FEHBA." *Id.* (citation omitted).[5]

The only significant difference between FEHBA's and ERISA's preemption provisions is that, with the exception of laws regulating insurance, ERISA preempts all state laws relating to ERISA plans, while FEHBA preempts state laws that are inconsistent with FEHBA contracts. Insofar as petitioner contends that his state tort claims escape preemption because they are consistent

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sion was necessary. He therein quoted the opinion of the Commission's General Counsel:

> The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy of the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached.

S. Rep. No. 903, 95th Cong., 2d Sess. 8 (1978).

[5] Petitioner attempts to escape the conclusion reached in *Pilot Life* by claiming that FEHBA, unlike ERISA, lacks a detailed and comprehensive enforcement mechanism. Pet. 27. Yet 5 C.F.R. § 890.105 not only provides for administrative review of denied claims, but OPM's determination that a claim is covered under a FEHBA plan is binding on the carrier by statute. *See* § 8902(j). If the enrollee disagrees with OPM, the regulations provide that the carrier can be sued "to recover on a claim," and that OPM can be sued "to review . . . a decision made by OPM." § 890.107. OPM also prescribes minimum standards for carriers, § 8902(e), and performs routine audits on each carrier under § 8910 and 5 C.F.R. § 890.202(d). Finally, under 5 C.F.R. § 890.204, OPM has the authority to withdraw approval of a plan if the carrier does not properly discharge its contract obligations. Thus, petitioner's contention that state tort claims provide the only means for enrollees to enforce their rights under FEHBA is without foundation.

with FEHBA plans, that issue is governed by *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985).

In *Lueck*, an employee sought to recover for the alleged bad faith manner in which his disability claim was processed under a collective bargaining agreement pursuant to § 301 of the Labor Management Relations Act, 29 U.S.C. § 1859(a). These agreements are governed by federal law because the "subject matter of § 301(a) 'is peculiarly one that calls for uniform law.'" 471 U.S. at 210 (quoting *Teamsters* v. *Lucas Flour Co.*, 369 U.S. 95, 103 (1962)). The question before the Court was whether the tort of bad faith was independent of the contract or "whether evaluation of the tort claim is inextricably intertwined with consideration of the terms of the . . . contract." *Id.* at 213. Reasoning that the duty to act in good faith, like the explicit contractual duty to pay, "depends upon the terms of the agreement between the parties, both are tightly bound with questions of contract interpretation that must be left to federal law." *Id.* at 216. Thus, since "Congress has mandated that federal law govern the meaning given [§ 301] contract terms," this Court held that state tort claims, which "purport[] to give life to these terms in a different environment," are preempted. *Id.* at 218-19.

FEHBA contracts are federal contracts negotiated between OPM and various carriers pursuant to 5 U.S.C. § 8902 to provide health benefits to federal employees as a term and condition of their employment. *Christiansen* v. *National Savings & Trust Co.*, 683 F.2d 520, 530-32 (D.C. Cir. 1982). The interpretation of FEHBA contracts is governed exclusively by federal law. *Tackitt* v. *Prudential Insurance Co. of America*, 758 F.2d 1572, 1575 (11th Cir. 1985). *But see Howard* v. *Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), discussed at pp. 9-11, *infra*. Moreover, FEHBA contracts are federal procurement contracts which are "governed by federal, not state, law." *Delancy* v. *National Post Office*

Mail Handlers, No. 84-0695, slip op. at 8 (M.D. Pa. June 25, 1985). *See also United States* v. *Allegheny County*, 322 U.S. 174, 183 (1944).

Like § 301 agreements, the subject matter of FEHBA contracts requires that they be governed by uniform federal law: "[T]he policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977)." Pet. App. at B12. Following *Lueck*, the Court of Appeals held that petitioner's state tort claims were preempted because "[t]ort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract." Pet. App. at B13.

As in *Lueck*, petitioner's state tort claims, which "invariably expand" a carrier's financial obligations under its FEHBA contract, and which will increase the premiums paid by the government and the enrollees, "are inconsistent with the Plan and hence, preempted under § 8902(m)(1)." *Id. See also Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986); *Myers* v. *United States*, 767 F.2d 1072, 1074 (4th Cir. 1985).

II. There is no conflict of decisions warranting review

As we have seen, the court below rejected petitioner's state law claims on the ground that they are preempted by 5 U.S.C. § 8902(m)(1). That holding is in accord with the decisions of two other Circuits. *Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986), *Myers* v. *United States*, 767 F.2d 1072 (4th Cir. 1985).[6] But peti-

[6] Contrary to the assertion at Pet. 16, the Eleventh Circuit's decision in *Blue Cross & Blue Shield* has a full discussion of the legislative history of § 8902(m)(1). See 791 F.2d at 1504-05. The assertion that there is a "distinct lack of remedies available to FEHBA plan participants under federal law" (Pet. 16) is simply false. See p. 6, n.5, *supra*.

tioner contends that this interpretation conflicts with the decision of the Tenth Circuit in *Howard* v. *Group Hospital Service*, 739 F.2d 1508. Pet. 15-20. Petitioner errs because the Tenth Circuit said nothing which supports petitioner's reading of § 8902(m)(1).

The *Howard* opinion's discussion of § 8902(m)(1) is confined to a single footnote which, after quoting that provision, states in its entirety: "There is no indication that any law of Oklahoma conflicts with the medical necessity or any other provision of the Blue Cross contract." 739 F.2d at 1510, n.1. This is certainly not a holding that § 8902(m)(1) does not preempt federal law where there is a conflict.[7] Moreover, it is doubtful whether *Howard*'s sparse observation concerning § 8902(m)(1) would have had a precedential value in the Tenth Circuit even absent subsequent guidance from this Court. In any event, the intervening decisions in *Pilot Life* and *Lueck*, *supra*, establish that no state law claims may be based on a contract under FEHBA. See pp. 5-8, *supra*. Thus, to the extent that *Howard* holds to the contrary under § 8902(m)(1) or otherwise, it can no longer be deemed good law anywhere and cannot give rise to a conflict calling for resolution by this Court.

Since *Howard* dealt with § 8902(m)(1) only in a footnote, petitioner indulges in hyperbole, at best, when he asserts that "the *Howard* court sets forth a thoughtful and well-reasoned basis for concluding that § 8902(m)(1) does not preempt state law actions for recovery on

[7] On the contrary, to the extent that the foregoing can be taken as an interpretation of the federal statute, it implies—and we put it no higher—that § 8902(m)(1) would preempt state law to the extent of any conflict. Such is the case here. If petitioner's claim for breach of contract were to be sustained under California law, the law of California would, to that extent, conflict with the contract as it has been interpreted by the court below in this case (Pet. App. at B10-11). Additionally, *Allis-Chalmers* v. *Lueck*, *supra*, establishes that the noncontractual claims which petitioner asserts under California law would conflict with FEHBA.

individual claims under FEHBA insurance plans." (Pet. 16.) In fact, the *Howard* opinion discussed an entirely different question, whether—as the defendants there urged in reliance on *Clearfield Trust Co.* v. *United States*, 318 U.S. 363 (1943)—"because a government agency is a party to the FEP contract, federal law should apply to the interpretation of the medical necessity provision to promote uniformity of decision and interpretation of the contract." 739 F.2d at 1509. The *Howard* court held that state law applies, pointing to cases such as *Miree* v. *DeKalb County*, 433 U.S. 25 (1977), which had distinguished *Clearfield*. In so concluding, the *Howard* court erred, as we show briefly in the margin.[8] But for present purposes, the essential point is that the petition does not challenge that portion of the Court of Appeals' opinion which rejected his breach-of-contract claims. Pet. App. at B8-11. For, as one California Appellate Court recently observed, "[t]he analysis in *Howard* was limited to the contract claim; there was no reference to preemption in the majority opinion, and, as the concurring opinion stated, the existence of a federal preemption defense would be insufficient to invoke the existence of removal

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[8] The Tenth Circuit stated—correctly, we think—that under *Clearfield* and *Miree*, "when the federal government has an articulable interest in the outcome of a dispute, federal law governs." 739 F.2d at 1510. It acknowledged that "if diverse resolutions of a controversy would frustrate the operations of a federal program, * * * or have some direct effect on the United States or its treasury, then federal law applies." *Id.* at 1510-11. But the court determined that state law applies: "We fail to see how various state court adjudications of FEP benefits claims will frustrate the operation of that program or conflict with a specific national policy." *Id.* at 1511. This characterization was clearly wrong because of the importance of nationwide uniformity, and because state law rules which are more generous than federal law would provide increased premiums, which must be paid not only by the enrollees, but by the government. See p. 8, *supra*. Petitioner himself recognizes "the express Congressional purpose of providing federal employees with medical insurance benefits at the lowest possible cost to the government and to the employees." (Pet. 19.)

jurisdiction." *Hartenstine* v. *Superior Court*, 196 Cal. App. 3d 206, 241 Cal. Rptr. 756, 764 (1987).

Hartenstine squarely held that § 8902(m)(1) preempts state tort claims based on bad faith and violation of the California Insurance Code. 241 Cal. Rptr. at 763-66. Petitioner fails to mention *Hartenstine* although he contends, in his final argument, that the decision below conflicts with *Fields* v. *Blue Shield of California*, 163 Cal. App. 3d 570, 209 Cal. Rptr. 781 (1985). Of course, a conflict between a state intermediate court and a federal court of appeals is not sufficient under Rule 17 to justify the grant of certiorari. This is all the more true in light of *Hartenstine*, since the California Supreme Court is the proper forum, in the first instance, to resolve the controversy between two California appellate courts as to the preemptive effect of § 8902(m)(1) on California law. Moreover, *Fields*, like the Tenth Circuit's decision in *Howard*, has been overtaken by *Lueck* and *Pilot Life*.

The short of the matter is that petitioner's state law claims are preempted by § 8902(m)(1), and there is no viable conflict of decisions with respect to the interpretation of that provision.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

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PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

§ 890.105 Filing claims for payment or service.

(a) *General.* Each health benefits plan adjudicates claims filed under the plan. An enrollee must initially submit all claims to the health benefits plan in which he or she is enrolled. If the plan denies a claim, the enrollee may ask the plan to reconsider the denial. If the plan affirms its denial or fails to respond as required by paragraph (b) of this section, the enrollee may ask OPM to review the claim.

(b) *Timeframes for reconsidering a claim.* (1) The plan must reconsider its initial denial of a claim (or a portion of a claim) when an enrollee submits a written request for reconsideration to the plan within 1 year after the date of the notice to the enrollee that the claim was denied.

(2) Within 30 days after the date of receipt of a timely-filed request for reconsideration, the plan must (i) affirm the denial in writing to the enrollee; (ii) pay the bill or provide the service; or (iii) request from the enrollee or provider additional information needed to make a decision on the claim. If a plan requests additional information from a provider, it must simultaneously notify the enrollee of the information requested. When additional information is requested, the plan must, within 30 days after the date the information is received, affirm the denial in writing to the enrollee or pay the bill or provide the service. If the enrollee or the provider does not respond within 60 days after the date of the plan's notice requesting additional information, the plan will make its decision based on the evidence it has. The plan must then send written notice to the enrollee of its decision on the claim. If the plan fails to act within 30

days after the enrollee's request for reconsideration or the plan's receipt of additional information, the enrollee may request OPM review as provided in paragraph (b) (3) of this section.

(3) If a plan either affirms its denial of a claim or fails to respond to an enrollee's written request for reconsideration within 30 days after the date it receives the request or within 30 days after the date it receives additional information requested, the enrollee may write to OPM and request that OPM review the plan's decision. The enrollee must submit the request for OPM review within the timeframes specified in paragraph (d) (1) of this section.

(4) A plan may extend the time limit for an enrollee's submission of additional information to the plan when the enrollee shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) When requesting the plan to reconsider a claim, the enrollee must put the request in writing and give the reason the claim should not have been denied.

(2) If the plan needs additional information from the enrollee to make a decision, it must (i) specifically identify the information needed; (ii) state the reason the information is required to make a decision on the claim; (iii) specify the timeframe (60 days after the date of the plan's request) for submitting the information; and (iv) state the consequences of failure to respond within the time limit specified, as set out in paragraph (b) (2) of this section.

(3) If the plan affirms the initial denial, it must provide written notice to the enrollee. This notice must inform the enrollee of (i) the specific and detailed reasons

for the denial; (ii) the enrollee's right to request a review by OPM; and (iii) the requirement that requests for OPM review must be received within 90 days after the date of the plan's notice of denial.

(d) *OPM review.* (1) OPM must accept a request for review that is received (i) within 90 days after the date of the plan's notice to the enrollee that the denial was affirmed; or (ii) if the plan fails to respond to the enrollee as provided in paragraph (b)(2) of this section, within 120 days after the date of the enrollee's timely request for reconsideration by the plan or the date the enrollee is notified that the plan is requesting additional information. OPM may extend the time limit for an enrollee's request for OPM review when the enrollee shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by a plan, OPM may (i) request that the enrollee submit additional information; (ii) obtain an advisory opinion from an independent physician; or (iii) obtain any other information as may in its judgment be required to make a determination. (OPM's request for an advisory opinion will not identify the enrollee or patient, the plan, or any medical institutions or physicians involved in the claim.)

(3) When OPM requests information from a plan, the plan must release the information within 30 days after the date of OPM's written request unless a different timeframe is specified by OPM in its request. Any evidence submitted by the enrollee or by the plan for review of the denied claim will be held as privileged information and will be reviewed only by persons having official need to see it.

(4) Within 30 days after receipt of the necessary evidence, OPM will give a written notice of its decision to the enrollee and the plan.

[51 FR 18564, May 21, 1986]

§ 890.107 Legal actions.

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations under this part or of a decision made by OPM should be brought against the Office of Personnel Management, Washington, DC 20415. However, an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

[51 FR 18565, May 21, 1986]

§ 890.202 Minimum standards for health benefits carriers.

* * * *

(d) It must permit representatives of OPM and of the General Accounting Office to audit and examine its records and accounts which pertain, directly or indirectly, to the plan at such reasonable times and places as may be designated by OPM or the General Accounting Office.

* * * *

§ 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a)(1) Comprehensive medical plans should apply for approval by writing to the Office of Personnel Manage-

ment, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31 of the year preceding the contract year. For contract year 1986 only, the letter application and attachments may be submitted as late as March 6, 1985. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year to be considered for participation in that contract year. OPM may make counterproposals at any time.

(2) Application for approval of employee organization plans may be made by letter to the Office of Personnel Management, Washington, DC 20415, after December 31, 1978, and before January 1, 1980. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the January 1 which is (i) at least 9 months after OPM receives the application and (ii) at least 6 months after OPM receives all evidence to demonstrate that the plan has met all requirements for approval.

(b) Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a "call letter" shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing,

specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM, shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 3 months preceding the contract period to which they will apply.

[37 FR 20668, Oct. 3, 1972, as amended at 41 FR 40090, Sept. 17, 1976; 43 FR 52461, Nov. 13, 1978; 48 FR 16232, Apr. 15, 1983; 50 FR 8315, Feb. 28, 1985]

§ 890.204 Withdrawal of approval of health benefits plans.

(a) The Director may withdraw his or her approval of a health benefit plan or carrier.

(b) Before withdrawing approval, the Director shall cause to be sent, by certified mail, a notice of the carrier stating that he or she intends to withdraw OPM approval of a health benefits plan therefor. The carrier is entitled to reply in writing within 15 days of its receipt of the notice, stating the reasons why approval should not be withdrawn.

(c) On receipt of the reply, or in the absence of a timely reply, the Director shall set a time and place for hearing. The Director shall conduct the hearing or designate a representative to do so, unless the carrier waives hearing. The carrier shall be given notice thereof, by certified mail, at least 15 days in advance of the hearing.

The carrier is entitled to appear by representative and present oral and written evidence and argument in opposition to the proposed action.

(d) The Director shall make his or her decision on the record and communicate it to the carrier by certified mail. The Director may set a future effective date for withdrawal of his or her approval.

(e) The Director, in his or her discretion, may reinstate approval of a finding that the reasons for withdrawing approval no longer exist.

[33 FR 12510, Sept. 4, 1968. Redesignated at 49 FR 1046, Jan. 9, 1984]

§ 890.301 Opportunities to register to enroll and change enrollment

* * * *

(d) *Open season.* (1) An open season will be held from the Monday of the second full workweek in November through the Friday of the first full workweek in December in any year—

(i) That precedes a year during which the rates or benefits of any health benefits plan in the program will change; or

(ii) That precedes a year during which a newly-approved plan will begin participation in the Program; or

(iii) At the end of which an existing health benefits plan will cease to participate in the Program.

(2) The Director of the Office of Personnel Management may modify the dates specified in this paragraph or announce additional open seasons. Announcements of open seasons will be made by OPM in Federal Personnel Manual (FPM) Bulletins.

(3) During open season—

(i) An eligible unenrolled employee may register to be enrolled.

(ii) An enrolled employee, annuitant, or former spouse may change to another plan, another option, or from self alone to self and family, or may make any combination of these changes.

* * * *

§ 890.302 Coverage of family members.

* * * *

(d) *Child incapable of self-support.* When an employee, annuitant, or former spouse enrolls for a family which includes a child who has become 22 years of age and is incapable of self-support, the employing office will require such enrollee to submit a physician's certificate verifying the child's disability. The certificate must—

(1) State that the child is incapable of self-support because of a physical or mental disability that existed before the child became 22 years of age and that can be expected to continue for more than 1 year;

(2) Include a statement of the name of the child, the nature of the disability, the period of time it has existed, and its probable future course and duration; and

(3) Be signed by the physician and show the physician's office address. The employing office will require the employee, annuitant, or former spouse to submit the certificate on or before the date the child becomes 22 years of age. However, the employing office may accept otherwise satisfactory evidence of incapacity not timely filed.

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No. 87-818

Supreme Court, U.S.
FILED
JAN 22 1988
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

VS.

PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION BY RESPONDENT THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

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QUESTIONS PRESENTED

This case does not involve insurance in the traditional sense. This case involves a "Health Benefits Plan" for federal employees, created by the Federal Employees Health Benefits Act of 1959 ("FEHBA"). 5 U.S.C. §§ 8901-8913. Respondent National League of Postmasters of the United States ("Postmasters") is an association of federal employees and is a "carrier" under FEHBA. Postmasters, as a carrier, provides health care benefits to federal employees through a Health Benefits Plan ("Plan").

Respondent The Prudential Insurance Company of America ("Prudential") administered claims presented to Postmasters for payment and, in effect, guaranteed Postmasters' solvency to pay valid claims. Prudential did not insure the federal employees who enrolled in the Postmasters' Health Benefits Plan.

The questions presented are:

1. Where FEHBA Health Benefits Plans come into existence through a federal contract, are subject to direct oversight by a federal agency, are funded by the federal treasury for the benefit of federal employees pursuant to a federal statute, and, where FEHBA itself contains an express preemption clause, whether disputes concerning FEHBA Health Benefits Plan benefits and administration shall be governed exclusively by federal law and all state law claims be preempted?

2. Whether Prudential is a proper party defendant in this matter and whether any claim is cognizable at all against Prudential under either federal or state law?

LIST OF PARTIES

The parties to the proceedings below were petitioner Kip Hayes, respondent National League of Postmasters of the United States, the Office of Personnel Management, an agency of the United States ("OPM"), Nobel Hayes, and respondent The Prudential Insurance Company of America.*

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*A list of Prudential's subsidiaries and affiliates pursuant to Rule 28.1 is contained in Appendix "G," attached hereto.

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CASE NO. 87-818

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

VS.

PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION BY RESPONDENT THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

OPINIONS BELOW

The Order of the United States District Court, Southern District of California (Nielson, L.C.), granting respondents' motion for summary judgment has not been reported. It is re-printed in Appendix "A", attached hereto.

The opinion of the United States Court of Appeals for the Ninth Circuit affirming the district court's order granting respondents' motion for summary judgment is

reported at 819 F.2d 921 (9th Cir. 1987), and is reprinted in Appendix "B", attached hereto.

The order of the United States Court of Appeals for the Ninth Circuit denying petitioner's petition for rehearing in the Ninth Circuit Court of Appeals, is reprinted in Appendix "C", attached hereto.

JURISDICTION

Petitioner originally brought this action in the Superior Court of California, County of San Diego, on April 16, 1984. Respondent Postmasters removed the action to the United States District Court for the Southern District of California, alleging federal jurisdiction pursuant to 28 U.S.C. §§ 1331, 1332(a) and 1441.

Respondents brought a motion for summary judgment. This motion was granted by the District Court on January 14, 1985.

Petitioner filed a timely appeal to the Ninth Circuit Court of Appeals. On June 15, 1987, the Ninth Circuit Court of Appeals issued an order affirming the District Court's order. The petition for rehearing was timely sought and subsequently denied on July 21, 1987.

On October 2, 1987, Justice O'Connor ordered that the time for filing the petition for a writ of certiorari be extended through November 18, 1987. The jurisdiction of this Court to review the judgment of the Ninth Circuit is sought pursuant to 28 U.S.C. § 1254(1). The Petition was timely filed.

On December 4, 1987, permission was granted by this Court to respondents that the Briefs in Opposition to the Petition may be filed on or before January 22, 1988.

STATUTE AND REGULATIONS INVOLVED

The Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§ 8901-8913. Pertinent sections of FEHBA are reprinted in petitioner's Appendix at D-1 through D-56.

Title 5 C.F.R. Part 890. These regulations, in pertinent part, are reprinted in Appendix "D", attached hereto.

STATEMENT OF THE CASE

Prudential hereby adopts and incorporates by reference as though set forth in full herein the Statement of the Case in the Opinion below by the United States Court of Appeals for the Ninth Circuit, 819 F.2d 921 (9th Cir. 1987) (Appendix "B"). Further, Prudential hereby adopts and incorporates by reference as though set forth in full the Statement of the Case set forth in the Brief in Opposition, and appendices thereto, filed in this matter by respondent Postmasters.

REASONS TO DENY THE PETITION

I.

SUMMARY OF ARGUMENT

Petitioner seeks to take an unusual set of facts, and insert a unique reading of a state law into federal contracts affecting federal employees. Moreover, this result is sought in a procedural context that renders this Court's opinion strictly advisory.

Petitioner wishes to use the California state law covenant of good faith and fair dealing to regulate the relationship between OPM and Postmasters, and to alter the federal contracts between all the parties here. This Petition does not meet the standards of this Court for the granting of a Petition for Writ of Certiorari.

First, based on express statutory and regulatory provisions, legislative history, and relevant case law, the decision below by the Ninth Circuit is correctly decided. Second, there is no bona fide conflict among the Courts of Appeals for the Circuits. The only Court of Appeals case cited by petitioner as "in conflict" is not apposite, and is not in conflict. Third, petitioner has adopted a highly strained and incorrect view of California state law. Even if California state law were applied, petitioner could not prevail.

Although petitioner attempts to garb himself under the broad theoretical cloak of "preemption," in fact, his main argument is very limited and almost outlandish. Petitioner proposes that under the facts of this case, California state law be inserted into the relationship between OPM, a federal agency, and Postmasters, a federal contractor, to contradict rights expressly given by federal statute to Postmasters. (*Petition*, p. 14 n.13). This type of intrusion by state law into the federal province was expressly prohibited by Congress with the passage of FEHBA.

A recent California Court of Appeal case has recognized these dangers and has held that FEHBA preempts all California state law claims for relief. *Hartenstine v. Superior Court*, 196 Cal. App. 3d 206 (1987).

Finally, no effective appeal was taken from a decision below and the action sought from this Court is only an advisory opinion.

II.

THE NINTH CIRCUIT CORRECTLY DECIDED THAT CALIFORNIA INSURANCE LAW IS PREEMPTED BY FEDERAL LAW AND THEREFORE CANNOT APPLY.

Petitioner presents to this Court the proposition that a federal employee Health Benefits Plan created by federal statute for federal employees and paid for in major part by the federal treasury should be subject to overriding state regulation.

Express congressional intent and an obvious federal interest in uniformity of benefits and procedures outweigh the interests of individual states which seek to impose differing standards on these federal employee Health Benefits Plans.

A. Under Applicable Preemption Doctrine, State Insurer Torts Would Defeat the Full Purpose and Objective of Congress.

State tort actions are expressly preempted by FEHBA. Congressional intent to preempt state law is apparent from 5 U.S.C. § 8902(m)(1), which provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits *(including payments with respect to benefits) shall supersede and preempt any state or local law,* or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions. (Emphasis added.)

The Ninth Circuit correctly relied upon this clear language in its decision below that California state laws

purporting to add additional procedures and remedies are preempted.[1]

The Ninth Circuit also cited a portion of the legislative history to support its conclusion. Indeed, a more detailed view of the legislative history of § 8902(m)(1) establishes firmly that Congress intended to supersede the application of all state claims-processing laws.

Alan Campbell, Chairman of the Civil Service Commission, then responsible for oversight of federal Health Benefits Plans, proposed and urged the passage of § 8902(m)(1). A letter from Mr. Campbell to Senator Abraham A. Ribicoff, Chairman of the Committee on Governmental Affairs articulated the problem of inconsistency within the fifty states in regard to FEHBA:

> In terms of contracting with the carrier, it was reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we

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[1]This Court, and other courts, have recognized that parallel preemption provisions under similar federal statutes have conclusive preemptive effect. An example is *Metropolitan Life Ins. Co. v. McSheen*, 577 F. Supp. 165 (N.D. Cal. 1983) which held that federal law will be used to interpret the terms of a group life insurance policy offered as a fringe benefit to federal employees pursuant to the Federal Employees Group Life Insurance Act, 5 U.S.C. § 8701 *et seq.* *See also, e.g.*, Servicemens Group Life Insurance Act, 38 U.S.C. § 765 *et seq.*, given preemptive effect in *Ridgway v. Ridgway*, 454 U.S. 46, 102 S.Ct. 49, 75 L.Ed.2d 39 (1981); Federal Employee's Group Life Ins. Act, 5 U.S.C. § 8709, given preemptive effect in *Metropolitan Life Ins. Co. v. Curtis*, No. CV-83-167 MML (C.D. Cal. 1983) (reprinted in Appendix "E", attached hereto). *Accord Atlas Pallet, Inc. v. Gallagher*, 725 F.2d 131, 135 (1st Cir. 1984) (federal law governs policies issued pursuant to National Flood Insurance Program); *Suydam v. United States*, 404 F.2d 1329, 1331 (D.C. Cir. 1968) (federal law governs policies issued by National Service Life Insurance, 38 U.S.C. § 801 *et seq.*

> would continue to place our carriers in a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with each other.

S. Rep. No. 95-903, 95th Cong., 2d Sess. ("S. Rep. No. 95-903") *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1419.

As FEHBA moved through the passage process, additional legislative history set out a broad interpretation of the preemption provision in Section 8902(m)(1). Senate Report No. 95-903 concludes that only state laws dealing with technical matters such as "the payment of premium taxes and requirements for statutory reserves" are to survive the effects of Section 8902(m)(1). (S. Rep. 95-903, *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1415.)[2] Petitioner's state law causes of action relating to claims administration do not fall within this category.

A fair reading of the entire legislative history indicates that Congress and the Civil Service Commission (predecessor to OPM) were extremely concerned about displacing all state regulation of federal employee Health Benefits Plans. Congress intended that federal employee Health Benefits Plans have national uniformity of benefits and procedures.[3]

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[2]The parallel House Report containing FEHBA legislative history, H. R. Rep. No. 282, 95th Cong., 1st. Sess. 5 (May 10, 1977) also makes clear that the only state regulations to be permitted were taxes and technical rules such as those involving maintenance of reserves. The content of plan coverage and matters "relating to health benefits" were expressly preempted.

[3]*See, e.g.*, Testimony of Thomas Tinsley, Dir., Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission before Senate Subcommittee on Civil Service and General Services (September 14, 1977), (Commission needed preemption in areas "where . . . our *administrative* practices are in conflict with

B. State Claims Processing Torts Directly Conflict With Federal Contractual, Statutory and Regulatory Remedies.

Preemption is further indicated by the broad language of § 8902(m)(1) stating that any state law "which relates to health insurance or plans," 29 U.S.C. § 8902(m)(1), will be superceded and preempted. This same wording in § 514 of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144 was construed by this Court in *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983):[4]

> A law "relates to" an employee benfit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.

463 U.S. at 96-97, 103 S.Ct. at 2900, 77 L.Ed.2d at 501.

Petitioner argues that FEHBA does not preempt state tort causes of action relating to the handling or processing of claims because they do not directly appear to contradict federal law.[5] (*Petition*, p. 21 n.17.) This same

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State laws") p. 3; ("... in terms of *administrative* matters ... State laws would not be controlling in these areas.") p. 6; (preemption "would preserve the principle of uniformity of benefits and *administration* for enrollees in each FEHB Plan.") p. 5. (Emphasis added).

[4] *Accord Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) *rev'g on other grounds*, 722 F.2d 482 (9th Cir. 1983) (*see* fn.4), and *Pilot Life v. Dedeaux*, ____ U.S. ____, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987).

[5] Petitioner's argument that § 8902(m)(1) "does not conflict" with the state tort actions misses another obvious point. Petitioner's argument avoids any conflict simply by having state law interpret the underlying contract — the state tort would not conflict with the contract because state law would interpret the contract.

This circular argument cannot stand. The issue is which law provides the contract interpretation. Congress has made clear that only federal law will provide the necessary national uniformity.

point was rejected by this Court in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985) and by the California Court of Appeal in *Hartenstine v. Superior Court*, 196 Cal. App. 3d, 206, 217 (1987).[6]

In *Lueck*, a union-represented employee sought to bring state insurer tort actions against the insurance company engaged by his employer to provide disability insurance under a private employee benefits plan. The question arose whether § 301 of the Labor Management Relations Act of 1947, 29 U.S.C. § 185(a), preempted state tort law. This Court found preemption, rejecting an argument identical to the one raised by petitioner here.

In *Lueck*, the plaintiff asserted that state tort claims were "independent" of any contract claim, for example, the state tort of "unreasonably delaying payment". This Court said:

> [I]t is a question of federal contract interpretation whether there was an obligation under this labor contract to provide payments in a timely manner, and, if so, whether [the employer's] conduct breached that implied contract provision.

471 U.S. at 215, 105 S.Ct. at 1913, 85 L.Ed.2d at 218.[7]

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[6]*Accord Delancy v. Nat. Post Office Mail Handlers*, No 84-0495 (M.D. Pa. June 25, 1985), reprinted in Appendix "F," attached hereto.

[7]This Court continued in *Lueck:*

> The duties imposed and rights established through the state tort thus derive fom the rights and obligations established by the contract. . . . That being so, this tort claim is firmly rooted in the expectations of the parties that must be evaluated by federal contract law. * * *
>
> Because the right asserted not only derives from the contract, but is defined by the contractual obligation of good faith, any

The identical reasoning has been adopted by the California Court of Appeal in a dispute concerning a FEHBA Health Benefits Plan. In *Hartenstine, supra* at 218, the California Court of Appeal, citing favorably and quoting the Ninth Circuit's opinion below, held:

> "Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract."

Id. (quoting Hayes v. Prudential, 819 F.2d 921, 936 (9th Cir. 1987)).

Petitioner's further argument that there is no federal comprehensive civil enforcement mechanism under FEHBA (*Petition,* p. 27) is incorrect. FEHBA, and regulations issued pursuant to it, have a complete claims review procedure, 5 C.F.R. § 890.105, a hearing procedure, 5 C.F.R. § 890.106, and bases for legal causes of action against a carrier or OPM, 5 C.F.R. § 890.107. In addition, OPM has the authority to prescribe minimum standards of conduct and to withdraw approval from plans. 5 U.S.C. § 8902(e). Approval may be withdrawn from plans which unreasonably fail to pay claims. 5 C.F.R. § 890.205. All of these statutes and regulations are incorporated into the contract negotiated between OPM and Postmasters ("Contract"); state laws which set forth additional remedies are therefore in conflict with the

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attempt to assess liability here [under a tort theory] inevitably will involve contract interpretation.

* * * These questions of contract interpretation, therefore, underlie any finding of tort liability, regardless of the fact that the state court may choose to define the tort as "independent" of any contract question. Congress has mandated that federal law govern the meaning given contract terms. Since the state tort purports to give life to these terms in a different environment, it is preempted.

471 U.S. at 218-19, 105 S.Ct. at 1914-15, 85 L.Ed.2d at 219-20.

Contract and the incorporated statutes and regulations and are preempted.

Congress did not create a "claims processing tort" in this statutory and regulatory scheme. A state-created claims processing tort plainly conflicts with the fact that Congress did not create a claims processing tort under FEHBA. Congress created the remedies it thought fit and any additional remedies must therefore conflict with that decision.

The presence of this civil enforcement system in FEHBA provides the same reliable indicia of congressional intent as this Court found in ERISA. *Pilot Life v. Dedeaux, supra.* In FEHBA, not only did Congress expressly preempt state laws, it also created the sole remedial scheme. As in ERISA, this combination of actions unmistakably demonstrates congressional intent.[8]

C. FEHBA Plans Are Federal Procurement Contracts, Not Insurance.

FEHBA is a program heavily subsidized by the government for federal employees. The federal government, and hence the taxpayers, provides more than 60% of the necessary funding for the program.[9] There is a strong

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[8]Petitioner's argument that a "comprehensive civil enforcement scheme", as found in *Pilot Life v. Dedeaux,* ____ U.S. ____, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987), is a *sine qua non* for preemption is incorrect. (*Petition,* pp. 21-27). This Court's discussion on that point in *Pilot Life* was occasioned by the "savings clause" contained in ERISA, 29 U.S.C. § 1144(c), and came only after there had been a finding of preemption even without such a "comprehensive civil enforcement scheme." The absence of such a "scheme" does not defeat preemption, and its presence, as in FEHBA, strongly reinforces preemption.

[9]For example, in 1976 the federal government paid $1.4 billion of the total program cost of $2.2 billion. S. Rep. No. 95-903, *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1414.

federal interest, therefore, to assure that federal law control the administration of the program so the government may control the scope and costs of the program necessary to maintain its existence.[10] Imposition of liability for bad faith and punitive damages will severely restrict the federal purposes underlying the act.

The court in *Delancy v. Nat. Post Office Mail Handlers,* No. 84-0695 (M.D. Pa. 1985) (Appendix "F") specifically found that FEHBA Health Benefits Plans are not insurance, and are a "government procurement contract."[11]

D. Petitioner's Remaining Arguments Regarding Preemption Are Inapposite or Unpersuasive.

Petitioner's argument concerning the case of *Fields v. Blue Shield of California,* 163 Cal. App. 3d 570 (1985), must be viewed in light of the very recent *Hartenstine* case, *supra.*

In *Hartenstine,* the child of a federal employee, a FEHBA Health Benefits Plan enrollee, was admitted to a hospital for psychiatric treatment. The carrier in that

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[10]This impact on the federal treasury alone should result in a very strong federal interest. *See, e.g., Clearfield Trust Co. v. United States,* 318 U.S. 363, 367, 65 S.Ct. 573, 87 L.Ed. 838 (1941).

Moreover, it is a commonplace that only federal law will control contract interpretation of federal procurement contracts. *United States v. Allegheny County,* 322 U.S. 174, 183, 64 S. Ct. 908, 88 L.Ed. 209 (1944).

[11]While technically not insurance, FEHBA does "relate to the business of insurance" as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, and is therefore not in conflict with that Act. 15 U.S.C. § 1012(b). Moreover, the FEHBA legislative history specifically states that McCarran-Ferguson would not affect FEHBA's goal of federal preemption. (*See* S. Rep. No. 95-903 at 8 (1978), Statement of Alan Campbell, Chairman of the Civil Service Commission).

case declined to pay for certain hospital days because the days had not been "medically necessary" as that term was defined under the Plan. The federal employee brought suit alleging state law-based causes of action, including breach of contract and breach of a covenant of good faith and fair dealing.

The California Court of Appeal held that all state law causes of action were preempted by FEHBA. The Court of Appeal, citing federal law,[12] held that state claims processing torts invariably conflict with federal obligations and are therefore preempted. *Hartenstine, supra* at 221.

III.

PETITIONER COMES BEFORE THIS COURT REQUESTING AN ADVISORY OPINION.

No effective Notice of Appeal was in fact filed from the district court's binding decision below. The district court issued two summary judgment orders in two related, but not consolidated, matters before it. An effective Notice of Appeal was taken only from one of those two orders.

Nobel Hayes, a federal enrollee in the Postmasters' Plan and the father of Kip Hayes, petitioner here, was a defendant in the declaratory judgment action, Civil Action No. 84-0341(M). In the declaratory judgment action, the district court ruled that benefits were properly reduced to $10,000 per year. Nobel Hayes did not file a Notice of Appeal from this Order against him. The son, as a dependent beneficiary, cannot have greater rights than those of his father — the district court's order is as

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[12] *Pilot Life v. Dedeaux, supra; Allis-Chalmers v. Lueck, supra; Blue Cross & Blue Shield v. Dept. of Banking,* 791 F.2d 1501 (11th Cir. 1986); *Hayes v. Prudential Ins. Co., supra.*

binding on the son, as it is on the father. At the same time, however, Kip Hayes could not take an appeal from the declaratory relief action to which he was not a party.

The declaratory relief action order conclusively showed that no contract right was breached by respondents, and that state law causes of action were preempted. These conclusions are binding on Kip Hayes through the unappealed order binding on his father. Kip Hayes cannot now collaterally challenge these conclusions. Therefore, the instant Petition must be viewed as an advisory opinion. This is, of course, not an appropriate basis upon which to grant a petition for writ of certiorari.

Petitioner compounds this problem by not challenging in his Petition that portion of the opinion of the Ninth Circuit below holding that there has been no contract breach. Petitioner does not challenge in this Petition that the benefit level was properly reduced under applicable contract language and federal law.

This failure to appeal to the Ninth Circuit and failure to challenge herein the declaratory relief action order renders this Petition strictly advisory.

IV.

PRUDENTIAL AS AN "UNDERWRITER" AND AGENT IS NOT A PROPER PARTY AMENABLE TO SUIT UNDER FEDERAL OR STATE LAW.

Section 890.107 of the Code of Federal Regulations provides in pertinent part:

> An action to recover on a claim for health benefits should be brought against the *carrier* of the health benefits plan. An action to review the legality of OPM's regulation or a decision made by OPM should

> be brought against the Office of Personnel Management, Washington, D.C., 20415.

(Emphasis supplied.)

Article 2, Section 2.1 of the Contract between OPM and Postmasters establishes that Postmasters is the "carrier" and Prudential is the "underwriter." Since the regulation allows suits for benefits only against the "carrier" of the plan, Prudential, as the "underwriter," is not amenable to suit.[13]

Moreover, even if state law were to apply, petitioner may not maintain any claim for relief against Prudential.

The Contract between OPM and Postmasters is the source of Petitioner's claims for health benefits. Prudential, however, is not a party to that Contract: Prudential is an agent. As an agent, and not a party to the underlying contract, Prudential cannot be liable under California state law for a breach of a state law covenant of good faith and fair dealing in a contract it does not sign. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal.3d 809, 824 (1979), *cert. denied and appeal dismissed*, 455 U.S. 912 (1980); *Gruenberg v. Aetna Ins. Co.*, 9 Cal.3d 566, 576 (1973); *Austero v. Nat. Cas. Co.*, 62 Cal. App. 3d 511, 515 (1976);

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[13]In *Director, Edward Meyer Hospital v. Stetz*, 433 F. Supp. 323 (W.D.N.Y. 1977), a claim for hospital services filed by Stetz, a federal employee, had been denied. Stetz brought an action against the carrier, the United States Civil Service Commission ("Commission") (now OPM) and the United States to obtain reimbursement for the cost of Stetz' hospitalization. The court dismissed claims against the Commission and the United States, holding:

> Under the regulations promulgated by the Commission [now OPM], actions such as this suit are specifically authorized only against the carrier.

Id. at 325.

Iverson v. Superior Court, 57 Cal. App. 3d 168, 171 (1976).[14]

In addition, petitioner's suggested use of a state law covenant of good faith and fair dealing to regulate the relationship between OPM and Postmasters is almost surrealistic. (*Petition*, p. 14 n.13) Under FEHBA, OPM and Postmasters negotiate on an annual basis the terms of the following year's Plan. The statute is clear that the independent concurrence of both parties is necessary to reach agreement or amend a contract. OPM has no authority unilaterally to direct that Postmasters agree to any particular benefit. 5 U.S.C. § 8902.

Petitioner's argument that a state law can override this express federal statute between a federal agency and federal contractor has no support in case law or logic. In effect, petitioner argues that state law should preeempt federal law.

Moreover, even if viewed strictly as a matter of state law, petitioner's argument is meaningless because a federal employee Health Benefits Plan is *not* insurance; hence, California doctrines concerning insurance policies

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[14]In *Austero*, the California Court of Appeal held that the duty of good faith and fair dealing "derives from and exists solely because of" the contractual relationship between the parties, and that one who is not a "party to the underlying contract" may not be held liable for breach of an implied covenant, because "as to him no such convenant exists." *Id.* at 515. *Iverson* also holds that one who is not party to the insurance contract "is not bound by the implied covenant [of good faith and fair dealing] and owes no duty to the insured not to breach it." *Id.* at 171. In *Gruenberg*, the California Supreme Court ruled that agents and employees are "not parties to the agreements for insurance," and therefore "are not subject to an implied duty of good faith and fair dealing." It held that an action may not lie against an agent for breach of an implied covenant of good faith and fair dealing. *Id.* at 576. *Egan* expressly reaffirms *Gruenberg*, holding that agents are "not subject to the implied covenant." *Id.* at 824.

are inapplicable. Second, in any event, no California case has ever suggested that a good faith covenant requires a contract between an insurance company and a third party must be amended to provide an extension of non-vested coverage to an insured.

Finally, among other problems, there can be no breach of a covenant of good faith and fair dealing without a breach of the underlying contract. Petitioner acknowledges that there has been no breach of contract by his failure to challenge that portion of the Ninth Circuit's opinion below.

In summary, even if state law were to apply, petitioner could not prevail on any state-law based claim for relief.

V.

THE DECISION IN *HOWARD V. GROUP HOSPITAL SERVICE* IS NOT IN CONFLICT AND IS INAPPOSITE.

The California Court of Appeal in *Hartenstine, supra*, accurately analyzed *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), when it stated:

> [In *Howard*,] the Court held that a suit in an Oklahoma state court for damages in contract and tort resulting from Blue Cross' failure to pay claims under an FEHBA plan should not have been removed to the United States District Court on the basis of federal question jurisdiction (28 U.S.C. § 1441(b)). However, the analysis in *Howard* was limited to the contract claim; there was no reference to preemption in the majority opinion, and, as the concurring opinion stated, the existence of a federal preemption defense would be insufficient to invoke the exercise of removal jurisdiction. Accordingly, the

holding on *Howard* is irrelevant to the preemption issue in the case here.

* * *

Further, if we were to apply the reasoning in *Howard* on the jurisdiction issue to Hartenstine's tort claims in the case here, the result would be contrary to section 8902(m)(1)'s purpose, *supra*, of promoting uniformity in the administration of FEHBA's benefits.

Hartenstine, supra at 218-19.

The Tenth Circuit in *Howard* did not need to reach the issues upon which the Petition in this case relies. The discussion in *Howard* cited by petitioner is strictly *dictum*. Purported conflict with *dictum* in another Court of Appeals decision is not a sufficient ground upon which to grant a Petition for Writ of Certiorari.[15]

CONCLUSION

For the reasons set forth above, the Petition for Writ of Certiorari should be denied.

January 22, 1988.

Respectfully submitted,

JAMES S. CLINE
ANGEL GOMEZ, III
ADAMS, DUQUE & HAZELTINE

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[15]In any event, this Court's analysis in *Massachusetts Mutual Life Ins. Co.* v. *Russell, supra, Allis-Chalmers v. Lueck, supra,* and *Pilot Life v. Dedeaux, supra,* discussed in Section II, *supra,* leaves the reasoning in *Howard* in serious question.

APPENDIX A

APPENDIX A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

KIP HAYES,
Plaintiff,
v.
PRUDENTIAL INSURANCE COMPANY,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES,
and NOBEL A. HAYES,
Defendants.

Civil No. 84-1245-N(M)

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

FILED, JAN. 22, 1985
ENTERED, JAN. 23, 1985
Clerk, U.S. District Court Southern District of California
By S. Miller, Deputy

This matter came before this Court on January 14, 1985, for hearing on the motion for summary judgment of defendants Prudential Insurance Company and National League of Postmasters. Plaintiff Kip Hayes appeared by Harvey R. Levine of Shernoff & Levine. Defendant Prudential Insurance Company appeared by James S. Cline of Adams, Duque & Hazeltine, and defendant National League of Postmasters appeared by John T. Kotelly of Dickstein, Shapiro & Morin. Upon consideration of the arguments of counsel and the moving and opposing papers:

IT IS HEREBY ORDERED that defendants' motion for summary judgment is granted as to all counts of the plaintiff's complaint. This Court concludes as to counts

one and two of the complaint that benefits for private duty nursing care have been lawfully reduced to $10,000 per person per year in the 1984 Postmasters Benefit Plan and that defendants are not obligated to pay claims for private duty nursing benefits in excess of this amount during 1984 nor during any year thereafter so long as the limitation remains. As to the remaining counts in plaintiff's complaint, this Court concludes that these claims under California state laws are preempted under Title V, United States Code section 8902(m)(1).

IT IS SO ORDERED.

Dated: January 22, 1985.

LELAND C. NIELSEN,
United States District Judge

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APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KIP HAYES,

Plaintiff-Appellant,

v.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,

Defendants-Appellees.

Nos. 85-5527; 85-5528

D.C. Nos. CV-84-1245-LCN CV-84-0341-LCN

OPINION

Argued and Submitted
November 4, 1985—San Diego, California

Filed June 15, 1987

Before: James R. Browning, Charles Wiggins and Melvin Brunetti, Circuit Judges.

Opinion by Judge Brunetti

Appeal from the United States District Court for the Southern District of California
Leland C. Nielsen, District Judge, Presiding

SUMMARY

Public Employees

Appeal from two summary judgments. Affirmed.

Appellant Kip Hayes (Kip) is the son of Nobel Hayes (Hayes), a retired federal employee. Kip was injured in a high

school football game and became a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of the injury Kip was covered as a family member on his father's plan issued under the FEHBA. The plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan was modified to eliminate such benefits, Hayes enrolled in another FEHBA plan during an open season enrollment period during which changes were permitted. In 1982 Hayes switched to a plan offered by the National League of Postmasters (NLP). In 1983 the NLP was formulated to place a $10,000 limit on benefits for private duty nursing care. The limit was lifted for 1983, but instituted for 1984 and future years.

In February 1984, NLP filed a declaratory relief action in district court naming the Office of Personnel Management (OPM) [which negotiated with NLP regarding the scope of coverage of the plan] and Hayes as defendants. The district court granted summary judgment in favor of NLP on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 plan. In April 1984 Kip brought an action against NLP in state court arguing that his enrollment in the 1982 plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits. The action was removed to federal district court where the court granted summary judgment in favor of the defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA.

[1] Although neither Hayes or the OPM appealed the declaratory judgment action in favor of NLP, Kip requested that he be joined as a defendant in that action and the court consolidated the two cases. Kip therefore effectively appealed from the summary judgment in the declaratory relief suit.

[2] An FEHBA provision requiring that a carrier agree to pay in an individual case if OPM finds the family member is

entitled to payment under the terms of the contract does not grant OPM authority unilaterally to alter the terms of the plan, but only requires that the carrier comply with the OPM's interpretation of the plan. OPM's consistently held view is that appellant is not entitled to unlimited benefits under the plan. [3] Appellant also urges that an FEHBA provision providing for a contingency reserve grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. But the OPM's interpretation of the provision as requiring the carrier's concurrence before contingency reserve funds may be used is entitled to substantial deference. [4] Consistent with this view the OPM never invoked authority to direct payment of the additional benefits, and appellant has not challenged OPM's interpretation of its authority. [5] Appellant also contends that the Catastrophic Protection provision of the plan allows the benefits, [6] but this provision only requires payment of 100% of eligible expenses (as opposed to 80%) in some circumstances and does not operate independent of the $10,000 limitation on private nursing care. [7] The limitation on private duty nursing care restricts the eligible expenses subject to the Catastrophic Protection provision.

[8] Appellant's contention that his state law tort and contract claims are not preempted by FEHBA because the claims relate to the manner in which the claim was processed, not to the nature or extent of coverage or benefits, draws a distinction that cannot be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. [9] Because the state law claims invariably expand obligations under the terms of the plan, the claims are inconsistent with the plan and preempted by FEHBA. This holding is supported by the Supreme Court's decision that the Employee Retirement Income Security Act preempts state common law tort and contract claims for benefits. To the extent the state law claims are predicated on an alleged obligation to provide benefits in excess of the $10,000 limit the claims are moot.

COUNSEL

Harvey R. Levine, Rick L. Bove, and Janet Lewis, San Diego, California, for the plaintiff-appellant.

Edward R. Cohen, John T. Kotelly, Ira Mitzner and Elaine Metlin, Washington, D.C.; James S. Cline, Los Angeles, California; R. J. Coughlin, Jr., San Diego, California, for the defendants-appellees.

Phillip S. Neal, Washington, D.C.; James R. Barnett, Washington, D.C., for the amicus curiae.

OPINION

BRUNETTI, Circuit Judge:

This is an appeal from summary judgments granted in two consolidated cases, *Kip Hayes v. Prudential Insurance Co.*, No. 85-5527 (D.C. No. 84-1245), and *National League of Postmasters of the United States v. United States Office of Personnel Management and Nobel Hayes*, No. 85-5528 (D.C. No. 84-0341). We are asked to review the district court's rulings that federal employee health benefits lawfully may be reduced from year to year, and that the Federal Employee Health Benefits Act preempts state law tort and contract actions.

Though we are moved by the compelling circumstances surrounding Kip Hayes and his family, we find that the statute and health benefits plan we are called upon to construe require an unmistakable result. Until Congress acts to ensure continued coverage for federal enrollees who require long-term care, this court will be powerless to provide appellant with the remedy he seeks.

We affirm the district court.

I. THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT

The Federal Employee Health Benefits Act (FEHBA) established a comprehensive program to provide federal employees and retirees with subsidized health care benefits. 5 U.S.C. §§ 8901-8913 (1982 & Supp. 1987). Under the Act, the United States does not act as an insurer, but, through the Office of Personnel Management (OPM), contracts with various private carriers to develop health care plans with varying coverages and costs. The plans are for a term of one year, and are renegotiated annually.

After OPM negotiates changes with the carriers all federal enrollees are permitted to switch enrollment from one plan to another, regardless of their state of health, during a period called "open season." Each enrollee thus may obtain the most beneficial plan but is not guaranteed the same coverage in future years that had been available the preceding year.

The National League of Postmasters (NLP or Postmasters) is a nonprofit corporation and a carrier under FEHBA. Each year, OPM and Postmasters negotiate a contract that determines the benefits Postmasters will provide that year to enrollees in the Postmasters Health Benefits Plan (Plan). The contract between OPM and Postmasters sets forth the precise terms of coverage under the Plan. OPM then issues a Postmasters Benefit Brochure (Brochure) which provides a complete description of the benefits available to enrollees that year.

For several years, Prudential Insurance Company of America (Prudential) has entered into agreements with Postmasters whereby Prudential issues an annual policy to Postmasters which incorporates the terms and conditions of the Brochure as negotiated by Postmasters and OPM for the year. Pursuant to the policy, Prudential administers certain claims presented to Postmasters for payment and, in effect,

guarantees that Postmasters can pay the benefits due enrollees under the Plan.

II. FACTS AND PROCEEDINGS

Appellant Kip Hayes is the son of Nobel Hayes, a retired federal employee. Appellant was injured in a high school football game in November 1976, and was rendered a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of his injury, appellant was covered as a family member under a FEHBA plan in which his father was enrolled. This plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan later was modified to eliminate private duty nursing care benefits, Nobel Hayes enrolled during open season in another FEHBA plan that did provide unlimited benefits for private duty nursing care. By 1982, Nobel Hayes again had switched coverage, and enrolled in the plan offered by Postmasters, which at the time had no limits on benefits for private duty nursing care.

In October 1982, following negotiations between OPM and Postmasters, the 1983 Postmasters Plan was formulated to place a $10,000 limit on benefits for private duty nursing care. By subsequent agreement between OPM and Postmasters, the 1983 Plan was amended to remove the $10,000 limit.

The Postmasters Plans for 1984 and 1985 again contained a $10,000 limit on benefits for private duty nursing care. The 1984 and 1985 Plans were not amended and, through the date of the summary judgments in both cases, contained the $10,000 limitation.

In February 1984, Postmasters filed in district court a declaratory relief action naming OPM and Nobel Hayes as defendants. *NLP v. OPM*, D.C. No. CV-84-0341-LCN. Postmasters sought a declaration that private duty nursing care benefits provided under its 1982 Plan could be reduced in

subsequent policy contract years and that under its 1984 Plan Postmasters was not obligated to provide Kip Hayes with private nursing benefits in excess of $10,000.

In April 1984, appellant brought an action against Prudential and Postmasters in the Superior Court for the State of California. The action was removed to federal district court. *Hayes v. Prudential,* D.C. No. CV-84-1245-LCN. Appellant alleged that his enrollment in the 1982 Plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits, and that Postmasters and Prudential had breached the contract by refusing to provide unlimited benefits in 1984. Based on this theory of his rights under the Plan, appellant sought damages alleging various state law causes of action including breach of a duty of good faith and fair dealing, and breach of Cal. Ins. Code § 790.03 (West 1982).

The district court granted summary judgment in favor of Postmasters in *NLP v. OPM* on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 Postmasters Plan and that Postmasters accordingly was not required to pay claims in excess of that amount.

In *Hayes v. Prudential,* the court granted summary judgment in favor of defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA, 5 U.S.C. § 8902(m)(1).

III. DISCUSSION

1. *Effective Appeal.*

Postmasters and OPM contend that there has been no effective appeal from *NLP v. OPM.* The basis for this contention is that neither OPM nor Nobel Hayes, the named defen-

dants, have appealed, and the appeal by Kip Hayes is not effective because he was not a party to the action.

[1] A motions panel of this court, however, has determined that Kip Hayes' appeal in *NLP v. OPM* was effective. In his Memorandum of Points and Authorities in Opposition to Motion for Summary Judgment in the *NLP v. OPM* action, appellant requested that the district court join him as a defendant pursuant to Fed. R. Civ. P. 19. The district court treated appellant's request as a motion for consolidation with *Hayes v. Prudential,* and consolidated the cases. Consolidation by the district court led the motions panel to conclude that Kip Hayes effectively appealed from the summary judgment in *NLP v. OPM.*

2. *Standard of Review.*

We review de novo the district court's decision regarding the $10,000 limit on benefits and the preemption of state law claims. *See Darring v. Kincheloe,* 783 F.2d 874, 876, (9th Cir. 1986) (grant of summary judgment is reviewed de novo). Summary judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

3. *$10,000 Limit on Nursing Care Benefits.*

Appellant contends that the district court erred in granting summary judgment for appellees because (1) Postmasters and Prudential were required to comply with an OPM directive to provide him unlimited private duty nursing care benefits, and (2) the Plan's Catastrophic Protection provision requires Postmasters and Prudential to provide nursing care benefits without regard to the $10,000 limitation stated elsewhere in the policy.

a) *OPM Directive.*

Appellant cites two sections of FEHBA which he contends grant OPM the authority to require Postmasters and Prudential to provide him with unlimited nursing care benefits.

[2] 5 U.S.C. § 8902(j) provides that "[e]ach contract under this chapter shall require the carrier to agree to pay for or provide a health service . . . in an individual case if [OPM] finds that the . . . family member . . . is entitled thereto under the terms of the contract." This provision does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan. OPM's consistently held view is that, under the Plan's terms, appellant is *not* entitled to unlimited benefits. As a result, Postmasters and Prudential were not required, under section 8902(j), to provide appellant benefits in excess of the $10,000 limit.

Appellant also cites as support 5 U.S.C. § 8909(b)(2). That section states that OPM shall set aside not more than three percent of the payments to each FEHBA plan as a contingency reserve which may be used, among other purposes, to increase the benefits in the plan from which the reserves are derived. The contingency reserve is a resource OPM can use in negotiations with a carrier to expand plan benefits. The availability of such funds was central to the agreement between OPM and Postmasters to remove the $10,000 limit from the 1983 Plan.

[3] Appellant urges that section 8909(b)(2) grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. The provision apparently has not been construed by the courts. OPM interprets the provision as requiring the carrier's concurrence before contingency reserve funds may be used to extend benefits beyond those within the express terms of the Plan. OPM's interpretation of the provision is entitled to substantial deference, and will be upheld unless unreasonable. *See Filiberti v. Merit Sys. Protection Bd.*, 804 F.2d 1504, 1508 (9th Cir. 1986)

[4] We do not decide the nature or extent of OPM's authority under section 8909(b)(2). Consistent with its view that the carrier's concurrence was necessary, OPM never invoked

authority under the section to direct Postmasters to provide additional benefits. Appellant has not challenged OPM's interpretation of its authority under section 8909(b)(2), nor has he alleged that OPM had a duty to ensure that contingency reserve funds be used to provide him with increased benefits. OPM, in fact, was never named as a defendant in appellant's suit to obtain nursing care benefits.

Contrary to appellant's repeated assertions, the record indicates only that OPM unsuccessfully sought Postmasters' voluntary agreement to amend the 1984 contract. We find no legal or factual bases for appellant's claim that Postmasters or Prudential violated a binding OPM directive.

b) *Catastrophic Protection.*

[5] Appellant next contends that the Catastrophic Protection provision of the Plan ensures him unlimited private duty nursing care benefits. The provision, at page 20 of the Brochure, states:

> CATASTROPHIC PROTECTION
>
> Under the High Option, if, in a calendar year, the out-of-pocket expenses for coinsured eligible expenses exceed $1,000 for a person under Self Only ($2,000 per family under Self and Family) the Plan will pay 100% of the eligible expenses during the remainder of that calendar year.
>
> Expenses incurred for the treatment of mental, psychoneurotic and personality disorders are not included under the Catastrophic Protection Benefit.

[6] This provision requires Postmasters to pay 100% of eligible expenses (when out-of-pocket expenses exceed a certain amount) as opposed to 80% of such expenses it would pay in other situations. The provision does not, however, operate

independent of the $10,000 limitation on private nursing care.

[7] The operative language here is the phrase "eligible expenses." The eligible expenses for nursing care are set out immediately above the Catastrophic Protection provision:

> PRIVATE DUTY NURSING CARE BENEFIT
>
> Benefits for private duty nursing care by a professional registered nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) are limited to a maximum of $10,000 per person per calendar year.

Appellant's contention that the Catastrophic Protection provision requires Postmasters to provide unlimited private nursing care benefits renders meaningless the phrase "eligible expenses" and ignores the $10,000 limitation stated plainly on the same page of the Brochure and again on page 27. *See Garvey v. Prudential Ins. Co. of America,* 596 F. Supp. 1119, 1126 (E.D. Pa. 1984) (Catastrophic Protection provision is subject to the $10,000 limitation on benefits for private duty nursing care). We find no merit in appellant's alternative argument that the Brochure language is ambiguous and should be construed in his favor. *See Id.* at 1125-26.

4. *State Law Claims.*

The final issue before us concerns the extent to which FEHBA preempts state law. The district court granted summary judgment for appellees in *Hayes v. Prudential* on this issue on the ground that FEHBA's section 8902(m)(1) preempted appellant's state law claims.

This section reads:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or

> benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977).

The parties advance differing views concerning the extent of federal preemption under FEHBA. Appellees contend that the preemption provision is extremely broad, while appellant characterizes the provision as one of "limited preemption" which precludes only those state claims that apply to the "benefit structure" of the plan. The courts are not in agreement on this question. *Compare Blue Cross & Blue Shield of Florida, Inc. v. Department of Banking and Fin.*, 791 F.2d 1501 (11th Cir. 1986)(Florida's Unclaimed Property Act preempted to the extent it conflicts with federal employee benefit plan); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (state law which purports to allow recovery of additional benefits not contemplated by a federal insurance contract must be deemed inconsistent with and preempted by FEHBA); and *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985)("the interpretation of health insurance contracts is controlled by federal, not state, law") *with Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984) (approving state law interpretation of FEHBA Plan provisions).

[8] Appellant contends that his state law claims[1] are not

[1]Appellant alleged the following state law causes of action: (1) breach of contract, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of duties under Cal. Ins. Code § 790.03 (West 1982), (4) civil conspiracy to breach the implied covenant of good faith and fair dealing and to violate Cal. Ins. Code § 790.03 (West 1982), (5) common law fraud, and (6) breach of fiduciary duty.

preempted under section 8902(m)(1), because the claims relate to the manner in which Postmasters and Prudential *processed* his benefits, and not to the "nature or extent of coverage or benefits." No such distinction can be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-20 (1985) (state tort claim stemming from manner in which a Labor Management Relations Act insurance benefit claim was handled is not independent of insurance contract and therefore is preempted by federal law). Moreover, the claims "relate to" the plan under section 8902(m)(1) as long as they have a connection with or refer to the plan. *Blue Cross*, 791 F.2d at 1504. All appellants' state law claims refer to the plan, and therefore fall under the preemption clause.

[9] Because the state law claims invariably expand appellees' obligations under the terms of the Plan, the claims are inconsistent with the Plan and, hence, preempted under § 8902(m)(1). Our holding is supported by the Supreme Court's recent decision that the Employee Retirement Income Security Act (ERISA) preempts state common law tort and contract claims for benefits under an ERISA-regulated plan. *Pilot Life Ins. Co. v. Dedeaux*, 55 U.S.L.W. 4471 (U.S. Apr. 6, 1987)(No. 85-1043). ERISA's preemption clause is similar to section 8902(m)(1) of the FEHBA.[2] And the Court held that the state claims were preempted despite a saving clause, 29 U.S.C. § 1144(b)(2)(A), which has no counterpart in the FEHBA. Thus, we hold Hayes' state law claims are preempted by the FEHBA. We note that, to the extent the state law claims are predicated on an alleged obligation of appellees to provide benefits in excess of the $10,000 limit stated in the Plan, the claims are moot in light of our ruling that no such obligation existed.

[2]ERISA's preemption clause states that "the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a).

IV. CONCLUSION

Appellant has brought an effective appeal from the summary judgment in *NLP v. OPM*. Postmasters lawfully reduced private duty nursing care benefits to $10,000 in the 1984 and 1985 Plans, and was not required by OPM or the Catastrophic Protection provision to provide appellant with benefits in excess of that amount. Appellant's state law claims are preempted under 5 U.S.C. § 8902(m)(1). The judgment of the district court is AFFIRMED.

APPENDIX C

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KIP HAYES,
Plaintiff-Appellant,
vs.
PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Defendants-Appellees.

CA Nos. 85-5527
85-5528

DC Nos. CV-84-1245-LCN
CV-84-0341-LCN

ORDER

FILED, JUL 21, 1987
Cathy A. Catterson, Clerk
U.S. Court of Appeals

Before: BROWNING, WIGGINS and BRUNETTI, Circuit Judges.

Appellant's petition for rehearing is denied.

APPENDIX D

APPENDIX D

CODE OF FEDERAL REGULATIONS 29 C.F.R.

§ 890.104 Initial decision and reconsideration.

(a) *Who may file.* An employee or annuitant may request OPM to reconsider a decision of an employing office or an initial decision of OPM refusing to permit registration for or change of enrollment or refusing to permit enrollment of an individual as a family member.

(b) *Agency decision.* A request for reconsideration of an agency decision must be filed within 30 calendar days from the date of the written decision stating the right to reconsideration by OPM. The time limit may be extended as provided in paragraph (e) of this section.

(c) *Initial decision.* An OPM decision shall be considered an inital decision as used in § 890.104(a) above when rendered by OPM in writing and stating the right to reconsideration. However, a decision initially rendered at the highest level of review available within OPM will not be subject to reconsideration.

(d) *Reconsideration.* A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, claim number, if appropriate, name of carrier and reasons for the request.

(e) *Time limit.* A request for reconsideration of an initial OPM decision must be filed within 30 calendar days from the date of OPM's initial decision. OPM may extent the time limit on filing when the individual shows that he/she was not notified of the time limit and was not otherwise aware of it, or that he/she was prevented by circumstances beyond his/her control from making the request within the time limit.

(f) *Final decision.* After reconsideration, OPM shall issue a final decision which shall be in writing, and shall

fully set forth the findings and conclusions of OPM.

§ 890.105 Review of claim for payment or service.

(a) OPM does not adjudicate individual claims for payment or service under health benefits plans. Individual claims for payment or service are adjudicated by the health benefits plan in which the employee or annuitant is enrolled.

(b) If a claim (or portion of a claim) or a service is initially denied by a health benefits plan, the plan will reconsider its denial upon receipt within one year of the denial of written request for reconsideration from the employee or annuitant. Such written request should set forth the reasons why the employee or annuitant believes that the denied claim or service should have been paid or provided. The plan must affirm the denial in writing to the employee or annuitant, setting out in detail the reasons therefor, within 30 days after receipt of the request for reconsideration, or pay or provide the claim or service within such time, unless it requests additional information reasonably necessary to a determination. Such requests by the plan must specifically identify the additional information required and the reason or reasons therefor. If the information requested is not supplied within 60 days of the request therefor, the plan shall make its determination and notify the employee or annuitant as

provided elsewhere in this section.

(c) If a plan either affirms its denial of a claim, or fails to respond to a written request for reconsideration within 30 days of the request, the employee or annuitant may make a written request to OPM's Associate Director for Compensation for a review to determine whether the plan's denial is in accord with the terms of OPM's contract with the carrier of the plan. The plan shall provide written notice to the employee or annuitant of the right to request such a review when it affirms a denial after reconsideration. A request for review will not be honored if received by OPM more than 90 days from the date of the plan's affirmation of the denial. Nor will a request for review be honored if, upon request by the Associate Director, the employee or annuitant does not furnish authorization signed by the patient (or person capable of acting for the patient) for the release of medical evidence to the Associate Director.

(d) In reviewing a claim denied by a plan, the Associate Director will review copies of all original evidence and findings upon which the plan denied the claim and any additional evidence submitted to the Associate Director or otherwise obtained by the plan or Associate Director. Plans will release such evidence and findings to the Associate Director within 30 days of request therefor. Any evidence obtained by the Associate Director in connection with a review of the denied claim will be held privileged and confidential and will be reviewed only by persons having official need to see it.

(e) In reviewing a claim denied by a plan, the Associate Director may request the employee or annuitant to obtain and submit additional medical or hospital records. The Associate Director may also request a confidential advisory opinion from an independent physician, or such other information or evidence as may in the Associate Direc-

tor's judgment be required to evaluate the claim denial. An Associate Director's request for an advisory opinion shall not disclose the identity of the claimant or patient, the plan, or any medical institutions or physicians involved in the claim.

(f) Within 30 days after all evidence requested by the Associate Director has been received, it shall notify the employee and the plan of its findings on review.

§ 890.107 Legal actions.

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations or a decision made by OPM should be brought against the Office of Personnel Management, Washington, D.C. 20415.

§ 890.203 Initial decision and reconsideration.

(a)(1) Application for approval of comprehensive medical plans may be made by letter to the Office of Personnel Management, Washington, D.C. 20415. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the first day of the contract period which is: (i) At least nine months after OPM receives the application, and (ii) at least seven months after OPM receives benefit and rate proposals and all evidence to demonstrate that the plan has met all requirements for approval. At any time, OPM may make a counter-proposal or propose changes on its own motion.

(2) Application for approval of employee organization plans may be made by letter to the Office of Personnel Management, Washington, D.C. 20415, after December 31, 1978, and before January 1, 1980. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the January 1 which is (i) at least 9 months after OPM receives the application and (ii) at least 6 months after OPM receives all evidence to demonstrate that the plan has met all requirements for approval.

(b) Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a "call letter" shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 3 months preceding the contract period to which they will apply.

§ 890.205 Withdrawal of approval of health benefits plans.

(a) The Director may withdraw his or her approval of a health benefit plan or carrier.

(b) Before withdrawing approval, the Director shall cause to be sent, by certified mail, a notice of the carrier stating that he or she intends to withdraw OPM approval of a health benefits plan therefor. The carrier is entitled to reply in writing within 15 days of its receipt of the notice, stating the reasons why approval should not be withdrawn.

(c) On receipt of the reply, or in the absence of a timely reply, the Director shall set a time and place for hearing. The Director shall conduct the hearing or designate a representative to do so, unless the carrier waives hearing. The carrier shall be given notice thereof, by certified mail, at least 15 days in advance of the hearing. The carrier is entitled to appear by representative and present oral and written evidence and argument in opposition to the proposed action.

(d) The Director shall make his or her decision on the record and communicate it to the carrier by certified mail. The Director may set a future effective date for withdrawal of his or her approval.

(e) The Director, in his or her discretion, may reinstate approval on a finding that the reasons for withdrawing approval no longer exist.

APPENDIX E

APPENDIX E

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

METROPOLITAN LIFE INSURANCE COMPANY,
Plaintiff,

vs.

JACQUELINE G. CURTIS,
Defendant.

AND RELATED CROSS-CLAIM.

Case No. CV-83-167-MML

ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff brought this action for declaratory judgment. It asserts that it is not obligated to pay to defendant death benefits under the insurance policy issued to Alfred M. Curtis, Sr., defendant's husband. Defendant counterclaimed for money had and received, damages for bad faith, unfair and deceptive business practices and intentional infliction of emotional distress. Plaintiff moved for summary judgment. The motion was argued to the Court on July 11, 1983, and taken under submission. The Court now grants plaintiff's motion for summary judgment.

Plaintiff was the carrier of insurance for Alfred M. Curtis, Sr., under the Federal Employees' Group Life Insurance (FEGLI) Program. The insured designated his children as beneficiaries under the FEGLI policy in accordance with 5 U.S.C. § 8705(a) and 5 C.F.R. § 870.901. Thereafter, Curtis married defendant but did not change the designation of beneficiary under the FEGLI policy. When Curtis died, both the defendant and the children, designated beneficiaries of record, submit-

ted claims for death benefits with plaintiff. Plaintiff paid the benefits to the children of Curtis.

Defendant argues that the premiums on the FEGLI policy were paid out of Curtis's wages, community property under California law. Therefore, the insurance proceeds should be community property and Curtis's designation of his children as beneficiaries is ineffective to deprive defendant of her rights in the community property. Defendant relies on *Carlson v. Carlson,* 113 Cal. Rptr. 722 (1974), which awarded to the spouse half of the FEGLI policy proceeds and points to the Uniformed Services Former Spouses' Protection Act, 10 U.S.C. § 1408, as Congress' response to *McCarty v. McCarty,* 453 U.S. 210 (1981), expressing the legislative intent that state courts should be able to consider military retired pay as marital property according to the state's own domestic relations law. Defendant contends that a similar congressional intent should be found as to the FEGLIA, that state domestic relations law should also apply, because the preemption provisions of 5 U.S.C. § 8709 were to be effective only as to employees who died, were separated or retired after the date of enactment of § 8709. In other words, defendant argues that there was no federal preemption of state domestic relations law in the FEGLIA before October 10, 1980.

Defendant's reading of § 8709 to imply a prior congressional intent that community property law should apply to FEGLI cases is not supported by the language of the FEGLIA and related regulations nor by case law. Section 8705 unequivocally states that death benefits would be paid first to designated beneficiaries and then in the absence of designation to the spouse. Moreover, there were specific regulations for designating and changing beneficiaries, 5 C.F.R. § 870.901, and the insured's right to change the beneficiaries at any time might not be

waived nor restricted. Congressional intent in the FEGLIA has every appearance of being to allow the insured federal employee complete control over the planning of how to provide for his family by designating his beneficiaries. The provisions regarding designation of beneficiaries in the FEGLIA are similar to those in the Servicemen's Group Life Insurance Act, and it is clear that the federal statutory order of precedence of payment preempts state domestic relations law and that strict compliance with the federal requirements in designating beneficiaries was contemplated. *Ridgway v. Ridgway*, 454 U.S. 46 (1981), *Stribling v. U.S.*, 419 F.2d 1350 (8th Cir. 1969).

Defendant's suggestion that the Uniformed Services Former Spouses' Protection Act, 10 U.S.C. § 1408, should affect the instant case is not persuasive. The policies affecting military retirement pay are not necessarily governed by the same considerations as those governing death benefits.

Moreover, it is likely that any concern to let state domestic relations law have effect in cases like *McCarty, supra, Yiatchos v. Yiatchos*, 376 U.S. 306 (1964), and *Carlson, supra*, which involved federal programs and regulations, derives from a factor which is not relevant here. The courts in the last two cited cases were reluctant to allow federal regulations to be exploited in order to work a fraud upon the spouse's rights in community property. As to the congressional response to *McCarty*, 10 U.S.C. § 1408, directing that state domestic relations law should apply, conceivably, a serviceman might be less than enthusiastic about paying alimony and support to a former spouse and might take advantage of anti-attachment provisions in his military pension to avoid such payments. But fraud is not to be presumed if an insured does not designate his spouse but his children as beneficiaries, and

the purpose of the federal group life insurance programs is to allow the insured to choose how he will provide for his family.

The Court need not decide whether *Ridgway, supra*, has implicitly overruled *Carlson, supra*, since *Carlson* is not really apposite here, no fraud by the husband having been alleged. Nevertheless, even if fraud by the husband has been alleged, the defendant should not be able to prevail in a claim against plaintiff in this case. In *Carlson,* the spouse sought to recover from the children (designated beneficiaries) half of the proceeds of the FEGLI policy. In short, the duty of the carrier is clear under the federal statute: to pay the benefits to the beneficiaries designated according to federal regulation. If there were any fraud, the spouse's claim would be against the beneficiaries, not against the carrier.

Since the plaintiff, in paying benefits to the designated beneficiaries, has acted in accordance with its duty under federal law, defendant can have no claim against plaintiff arising from the latter's actions. The Court therefore grants plaintiff's motion for summary judgment and declares that it is not obligated to pay death benefits to the defendant under the FEGLI policy issued to Alfred M. Curtis, Sr.

IT IS SO ORDERED.

IT IS FURTHER ORDERED that the clerk shall serve, by United States mail, copies of this order on counsel for the parties in this matter.

Dated: July 29, 1983

/s/ MALCOM M. LUCAS
Malcom M. Lucas
United States District Judge

APPENDIX F

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

GARRY DELANCY AND DELORES DELANCY,
Plaintiffs,

v.

NATIONAL POST OFFICE MAIL HANDLERS, WATCHMEN, MESSENGERS AND GROUP LEADERS, A Division of Liuna; AFL-CIO; MAIL HANDLERS BENEFIT PLAN; and CONTINENTAL ASSURANCE CO. OF CHICAGO, ILL.,
Defendants.

Civil Action No. 84-0695

MEMORANDUM

This case is now before the court on defendants' Motion to Remand and for Partial Judgment on the Pleadings, or, in the alternative, for Summary Judgment.

Plaintiffs Garry and Delores Delancy brought suit to hold defendants National Post Office Mail Handlers Union, Mail Handlers Benefit Plan (MHBP or Plan) and Continental Assurance Co. of Chicago, Illinois (CAC) liable for compensatory and punitive damages on the basis of two separate but inter-related, claims for relief. In the first count, plaintiffs assert a breach of contract by defendants' failure to reimburse plaintiffs for certain medical expenses which Mrs. Delancy incurred while covered as a dependent by the Plan. In the second count, plaintiffs allege that defendants' conduct was intentional and in bad faith, thereby causing plaintiffs' emotional distress and giving rise to a right to recover compensatory and punitive damages.

The case was filed initially in the Court of Common Pleas of Cumberland County, Pennsylvania. It was removed to this court pursuant to 28 U.S.C. §§ 1441 and 1446 on the grounds that (1) the breach of contract claim

arises under federal law, and (2) the separate and independent state law claim falls within the doctrine of pendent jurisdiction (*United Mine Workers v. Gibbs,* 383 U.S. 715 (1966)); 28 U.S.C. § 1441(c). *See* Verified Petition for Removal, ¶ 6.

Defendants thereafter answered the Complaint and asserted a counterclaim which seeks restitution of certain health benefit payments which the Plan contends was made in error to Travacare Laboratories on plaintiff's behalf. Defendants further moved to stay discovery pending adjudication of this potentially dispositive motion. By order dated August 14, 1984, this court granted defendants' motion and stayed all discovery except that which plaintiffs deemed necessary to respond to this motion.

Defendants now move the court for an order remanding plaintiffs' claim that MHBP failed to pay benefits owed them, and defendants' counterclaim for benefits erroneously paid to plaintiffs to the United States Office of Personnel Management for its decision on review pursuant to 5 C.F.R. § 890.105. Alternatively, defendants move, pursuant to Rule 56(b) of the Federal Rules of Civil Procedure, that the court grant summary judgment in their favor.

Defendants further move pursuant to Rules 12(c) and 56(b), Federal Rules of Civil Procedure, for judgment on the pleadings, or, in the alternative, summary judgment on the second count of plaintiffs' Complaint because federal law preempts the claim raised therein.

Factual History

During 1982 and 1983, Garry Delancy, as a federal employee, and his wife Delores, as an eligible dependent, were enrolled in MHBP. In the first count of their Complaint, the Delancys assert that the Plan failed to pay

a valid claim for health benefits incurred in 1982 at the Chambersburg Hospital, Chambersburg, Pennsylvania.

Chambersburg Hospital filed with the Plan a claim assigned by the Delancys for $8,638.25 for services to Mrs. Delancy during a stay from September 29, 1982 to October 20, 1982. The hospital records indicate a diagnosis of "factitious illness." Prior to the adjudication of this claim, however, the Plan processed an earlier-filed claim from Hershey Medical Center in the amount of $3,089.25 for inpatient psychiatric care rendered to Mrs. Delancy upon her transfer there from Chambersburg Hospital on October 20, 1982.

In 1982, the Plan's hospital benefits for mental and nervous conditions were limited to $2,500.00 or the cost of fifty (50) days of hospitalization, whichever was less, during any six month period. Accordingly, the $2,393.50 paid by the Plan on the Hershey Medical Center claim was applied toward the $2,500.00 ceiling on hospital benefits for mental and nervous conditions for the six month period beginning September 29, 1982.

The documentation forwarded to the Plan by the Chambersburg Hospital disclosed that Mrs. Delancy had been hospitalized for the treatment of a "factitious illness." According to the Plan, "factitious illness" is listed by the International Classification of Diseases (ICD) under the heading "Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Disorders." Because the Plan defines "mental and nervous conditions" as those "listed in the [ICD] as psychoses, neuroses, personality disorders, and other non-psychotic mental disorders," the Plan subjected the Chambersburg Hospital claim to the $2,500.00 hospital benefit limitation for mental and nervous conditions. Therefore, because the Chambersburg Hospital claim had been incurred in the same six month period as the Hershey Medical Center claim, and because the Plan

had already paid $2,393.50 to Hershey Medical Center, only $106.50 in hospital benefits was available to be applied toward the Chambersburg Hospital claim. However, rather than make a payment of that amount to the Chambersburg Hospital, the Plan set off this amount against an erroneous $2,023.46 overpayment which it made to Travacare Laboratories on the Delancy's behalf.

Defendants' counterclaim arises out of its alleged overpayment to Travacare Laboratories. During the period September 1983 through February 1983, Travacare Laboratories submitted to the Plan claims for certain equipment and supplies delivered to the Delancy's residence, in the amount of $5,343.88. The Plan said Travacare the entire claim and alleges that it did so in the mistaken belief that it was all for durable medical equipment, an allowable expenditure under the Plan. Now the Plan argues that certain of the claimed expenses were for liquid nutrition which Mrs. Delancy consumed in her home. In 1982 and 1983, the Plan did not cover such supplies when not furnished during a hospital stay. The Plan asserts that it should not have paid Travacare $2,023.46 on the Delancy's account for the liquid nutrition supplies.

Discussion

Defendant MHBP is a health benefits plan sponsored by an employee organization carrier pursuant to the Federal Employees Health Benefits Act (FEHBA or the Act), 5 U.S.C. § 8901/8913. Thus, the MHBP is the product of a federal procurement contract negotiated between the sponsoring employee organization carrier, the Mail Handlers Union, and the United States Office of Personnel Management (OPM). *See* 5 U.S.C. § 8902.

FEHBA is a comprehensive statutory scheme regulating all aspects of federal employee health benefits plans,

including eligibility for coverage, 5 U.S.C. §§ 8902(f), 8905, 8908, standards for termination of coverage, §§ 8902(g) and (h), and benefit types, levels and rates, §§ 8902(d) and (i), 8904. In addition, FEHBA mandates that OPM has the authority to require carriers to pay benefits in any individual case if OPM finds the enrollee entitled to such under the contract with the carrier, § 8902(j), places general supervisory authority of the employee health benefits program established by statute in the hands of OPM and empowers OPM to issue regulations necessary to carry out the purpose of the Act, § 8913.

The Request for Remand

The Plan's contract with OPM, in accordance with statutory requirements found at 5 U.S.C. § 8902(j) and 8913, establishes a disputed claims review and resolution procedure which provides for OPM review of a FEHBA plan's decision to deny an individual claim for benefits. *See* 5 C.F.R. § 890.105. If, upon conducting such a review, OPM "finds that the [enrollee] is entitled [to the claimed benefit] under the terms of the contract" the Plan must pay the claim, notwithstanding its objection. 5 U.S.C. § 8902(j). Defendant argues that OPM has not had the occasion to review the benefit claim disputes which are now before the court for adjudication and that, as a matter of sound judicial policy, this court should remand the claims to OPM for administrative review.

Plaintiffs argue that their claim was not denied until after this lawsuit was commenced. In fact, plaintiffs aver that they have never been notified of the denial of their claim, although they have been informed by the hospital that the claim was denied. Absent a denial from the Plan, plaintiffs were without an administrative remedy and the exhaustion requirement should be waived.

Except where mandated by statute, the "exhaustion of administrative remedies is not an inexorable command, but is a matter of sound judicial discretion." *Cerro Metal Products v. Marshall,* 620 F.2d 964, 970 (3rd Cir. 1981). In exercising that discretion, the court must look to a number of factors, *see Susquehanna Valley Alliance v. Three Mile Island Nuclear Reactor,* 619 F.2d 231, 246 (3rd Cir. 1980), and is generally guided by the rationales advanced for this judicially created doctrine. Those purposes include: (1) the promotion of administrative efficiency by avoiding premature interference with agency processes; (2) respect for executive autonomy by allowing an agency to correct its own errors; (3) facilitating judicial review by giving the court the benefit of the agency's expertise; and (4) serving judicial economy by having the administrative tribunal compile the factual record. *Cerro Metal Products,* 620 F.2d at 970. The requirement also shows deference to another branch of government; when Congress has provided an administrative remedy which is capable of resolving a controversy, such a remedy should be utilized. *Id.* at 71; *American Fed. of Gov. Emp. Local 1994 v. Resor,* 442 F.2d 993, 994 (3rd Cir. 1971).

The Third Circuit has recognized only three exceptions to the exhaustion doctrine: (1) when the nonjudicial remedy is clearly shown to be inadequate to prevent irreparable injury; (2) when resort to the nonjudicial remedy would clearly violate statutory or constitutional rights; and (3) when exhaustion would be futile. *Republic Industries v. Central Pa. Teamsters,* 693 F.2d 290, 293 (3rd Cir. 1982). The court has also stated that "these exceptions apply only in 'extraordinary circumstances,' when the remedy to be exhausted, though supported by the underlying policy justifications of the doctrine, should not be compelled because of some countervailing justifica-

tions of the doctrine, should not be compelled because of some countervailing consideration." 693 F.2d at 294.

The court does not find any of the recognized exceptions applicable to the instant case and, indeed, finds that a remand would serve important interests. Congress, in enacting the statute, clearly intended that a governmental agency should be the initial forum for dispute resolution. The agency's procurement of this contract demonstrates a peculiar expertise in interpreting the contract provisions. Finally, the agency can assist the court in compiling a factual record should further judicial intervention be necessary.

Because no formal notice had been given at the time suit was commenced, plaintiffs could not exhaust administrative remedies and therefore, should not be penalized by dismissal of the suit. The court will remand plaintiffs' claim as well as defendants' counterclaim for administrative review, but will retain jurisdiction so that the parties may return to this court if the administrative remedy to resolve the dispute.

The Preemption Claim

In the second count of the Complaint, plaintiffs allege that MHBP's refusal to pay the Chambersburg Hospital claim in issue here is "without explanation" and "without basis." Plaintiffs assert that the refusal was "an intentional act of bad faith" and "negligent." (Complaint, ¶¶ 12-15). As a result of these actions, plaintiffs are alleged to have suffered severe emotional distress, fear, humiliation, embarrassment and mental anguish and demand compensatory and punitive damages.

It appears that plaintiffs allege a cause of action for insurer bad faith, a tort which has been recognized in some, but by no means all, jurisdictions. *Compare,* e.g., *Gruenberg v. Aetna Ins. Co.,* 9 Cal. 3d 566, 574, 510 P. 2d

1032, 1037, 108 Cal. Rptr. 480, 485 (1973), and *D'Ambrosio v. Pennsylvania National Mutual Casualty Ins. Co.,* 494 Pa. 501, 431 A.2d 966, 970 (1981). The MHBP is *not* an insurance contract governed by state law. As a creature of FEHBA, 5 U.S.C. § 8901 *et seq.,* the MHBP is a government procurement negotiated between the sponsoring employee organization carrier and OPM pursuant to 5 U.S.C. § 8902, to enable the Federal Government to offer to its employees health benefits as a term and condition of employment. As a federal procurement contract, it is governed by federal, not state, law. *Tackitt v. Prudential Insurance Co., et al.,* 758 F.2d 1572 (11th Cir. 1985).

Plaintiffs seek to impose common law tort liability on the government contractor. However, this court finds that the FEHBA, because of its comprehensive nature and special subject matter preempts application of state laws to the MHBP.

It is well established that within constitutional limits Congress may preempt state law by enacting a

> scheme of federal regulation so pervasive as to make reasonable the inference that Congress left no room to supplement it, because the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject
>
> . . . .
>
> *Pacific Gas & Electric v. State Energy Resources Conservation Devel. Comm'n,* ____ U.S. ____, 103 S.Ct. 1717, 1744 (1983); *see also Chicago N.W. Transportation Co. v. Kalo Brick & Tile Co.,* 450 U.S. 311, 317 (1981).

The nature of the subject matter regulated by the FEHBA — the provision of health benefits insurance for federal employees as a benefit of their employment — is one uniquely of federal concern.

In a recent decision which offers some assistance here, the Supreme Court has held that federal labor law preempts the same state law based insurer bad faith tort claim which plaintiffs here allege. *Allis Chalmers Corp. v. Lueck,* ____ U.S. ____, 53 U.S.L.W. 4463 (April 16, 1985). The specific issue in *Lueck* was whether section 301 of the Labor Management Relations Act, 29 U.S.C. § 185(a), preempted the Wisconsin state law tort action for bad faith delay in making disability payments due under a collectively bargained plan. 53 U.S.L.W. at 4464. In resolving that issue in favor of preemption, the Court noted that section 301 reflects a congressional policy that federal uniformity was to prevail over inconsistent local rules, 53 U.S.L.W. at 4465. Therefore,

> questions relating to . . . what legal consequences were intended to flow from breaches of that [federal law governed] agreement, must be resolved by reference to uniform federal law, whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort.

53 U.S.L.W. at 4465.

In order to accommodate these policies, the court found that the analysis must focus on whether the tort at issue confers state law rights independent of any right established by the federal law contract, or whether evaluation of the tort claim is inextricably intertwined with consideration of the terms of that contract. Thus, the Court held that "*[i]f the state tort law purports to define the meaning of the contract relationship, that law is preempted.*" 53 U.S.L.W. at 4466 (emphasis supplied).

Lueck seems particularly instructive in this case. Here the federal interest underlying FEHBA is dominant, thereby precluding state regulation, from two viewpoints: first, the cost of the program to the government and employees; and second, the necessity of uniform administration and decision-making in plans such as MHBP, which have enrollees in many states. If state laws and remedies were permitted to impose special requirements on FEHBA plans, the cost of business would increase over that of a uniformly regulated federal program. The need for uniform administration is particularly important when enrollees have multi-state contacts. *See, LaBelle v. Blue Cross & Blue Shield United of Wisconsin*, 548 F.Supp. 251, 253 (W.D. Wisc. 1982). Finally, the scheme of federal regulation here is so pervasive as to clearly indicate that Congress has precluded state regulation.[1]

To be sure, the holding in *Lueck* is not binding here and, indeed, is a narrow one. "We pass no judgment on whether this suit also would have been pre-empted by other federal laws governing employment or benefit plans." U.S.L.W. at 4468. However, the analysis is persuasive.

In addition, OPM interprets 5 U.S.C. § 8902(m)(1), the section which forms the basis for the Delancys' claim, to preempt state insurer bad faith tort claims. (Declaration of Kevin J. Burns, OPM Assistant Director for Insurance Programs, Exh. A to Barnett Declaration filed Feb. 8, 1985.) It is settled that the interpretation of a statute by an agency which is charged with administering that statute, shall be shown "great deference" by the courts,

---

[1]The scope of FEHBA's coverage includes conditions of eligibility for coverage, benefits, contributions and required reserves; qualifications of carriers, disclosure to employees, vesting of supervisory authority in a federal agency and original jurisdiction in the federal courts. 5 U.S.C. §§ 8902, 8903, 8904, 8906, 8909, 8912, 8913.

provided that the interpretation is a reasonable one. *Udall v. Tallman,* 380 U.S. 1, 6 (1965).

For the reasons already discussed, the court finds the agency's interpretation to be reasonable and is supported by the legislative history, as cited in the Burns declaration.

Accordingly, the court will grant judgment in favor of the defendants on the second count of the Complaint.

/s/ SYLVIA H. RAMBO

Sylvia H. Rambo
United States District Judge

Dated: June 25, 1985

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF
PENNSYLVANIA

GARRY DELANCY and DELORES DELANCY,
Plaintiffs,
v.
NATIONAL POST OFFICE MAIL HANDLERS,
WATCHMEN, MESSENGERS AND GROUP LEADERS,
A Division of Liuana; AFL-CIO;
MAIL HANDLERS BENEFIT PLAN; and
CONTINENTAL ASSURANCE CO. OF CHICAGO, ILL.,
Defendants.

Civil Action No. 84-0695

ORDER

In accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

1. The first count of the plaintiffs' Complaint and the defendants' counterclaim are remanded to the United States Office of Personnel Management for its review pursuant to 5 C.F.R. 890.105.

2. The defendants are to inform the court of the agency's disposition of these claims within ten (10) days of that decision, but in any event, shall report back to the court within ninety (90) days of the date of this order.

3. Judgment is granted in favor of the defendants and against the plaintiffs on the second count of the Complaint. The Clerk of the Court is directed to enter the judgment.

/s/ SYLVIA H. RAMBO
Sylvia H. Rambo
United States District Judge

Dated: June 25, 1985

APPENDIX G

APPENDIX G
List of Companies supplied pursuant to Rule 28.1

Prudential has no parent corporation. Prudential has no subsidiaries or affiliates which have outstanding any equity securities which are publicly traded. Set forth below is a list of corporations in which Prudential has, or has the right to acquire, more than 10% of a class of equity security which is publicly traded. These investments were acquired in the normal course of Prudential's investment operations and not for the purpose of acquiring control of these corporations.

Air Express International Corp.
BRNF Liquidating Trust
Communications Transmission, Inc.
C.P. National Corporation
DMI Furniture
Foodmaker, Inc.
Global Natural Resources
Grubb & Ellis
Intermet Corporation
Manufactured Homes
Maxus Energy
Miller Shoe Industries
Public Service Company of New Hampshire
Scan-Optics
Specialty Equipment Companies, Inc.
Tom Brown
Vista Chemical Co.
Wellman
Western Union Telegraph Co.
Prudential Special Equity Fund
United States High Yield Fund

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the City and County of Los Angeles; I am over the age of eighteen years and not a party to the within action; my business address is: 1706 Maple Avenue, Los Angeles, California.

On January 22, 1988, I served the within Brief in Opposition in re: "Kip Hayes vs. Prudential Insurance Co." in the United States Supreme Court, October Term 1987, No. 87-818;

On the Parties in said action, by placing Three copies thereof enclosed in a sealed envelope with postage fully prepaid, in the United States post office mail box at Los Angeles, California, addressed as follows:

Robert S. Greenspan, Esq.
Edward R. Cohen, Esq.
Appellate Staff, Civil Division
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110 West A Street, Suite 1260
San Diego, CA 92101

All Parties required to be served have been served.

I certify (or declare), under penalty of perjury, that the foregoing is true and correct.

Executed on January 22, 1988, at Los Angeles, California

Ce Ce Medina

CE CE MEDINA

Supreme Court, U.S.
FILED
FEB 19 1988
JOSEPH F. SPANIOL, JR.
CLERK

No. 87-818

In the Supreme Court of the United States

OCTOBER TERM, 1987

KIP HAYES, PETITIONER

v.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

CHARLES FRIED
Solicitor General
Department of Justice
Washington, D.C. 20530
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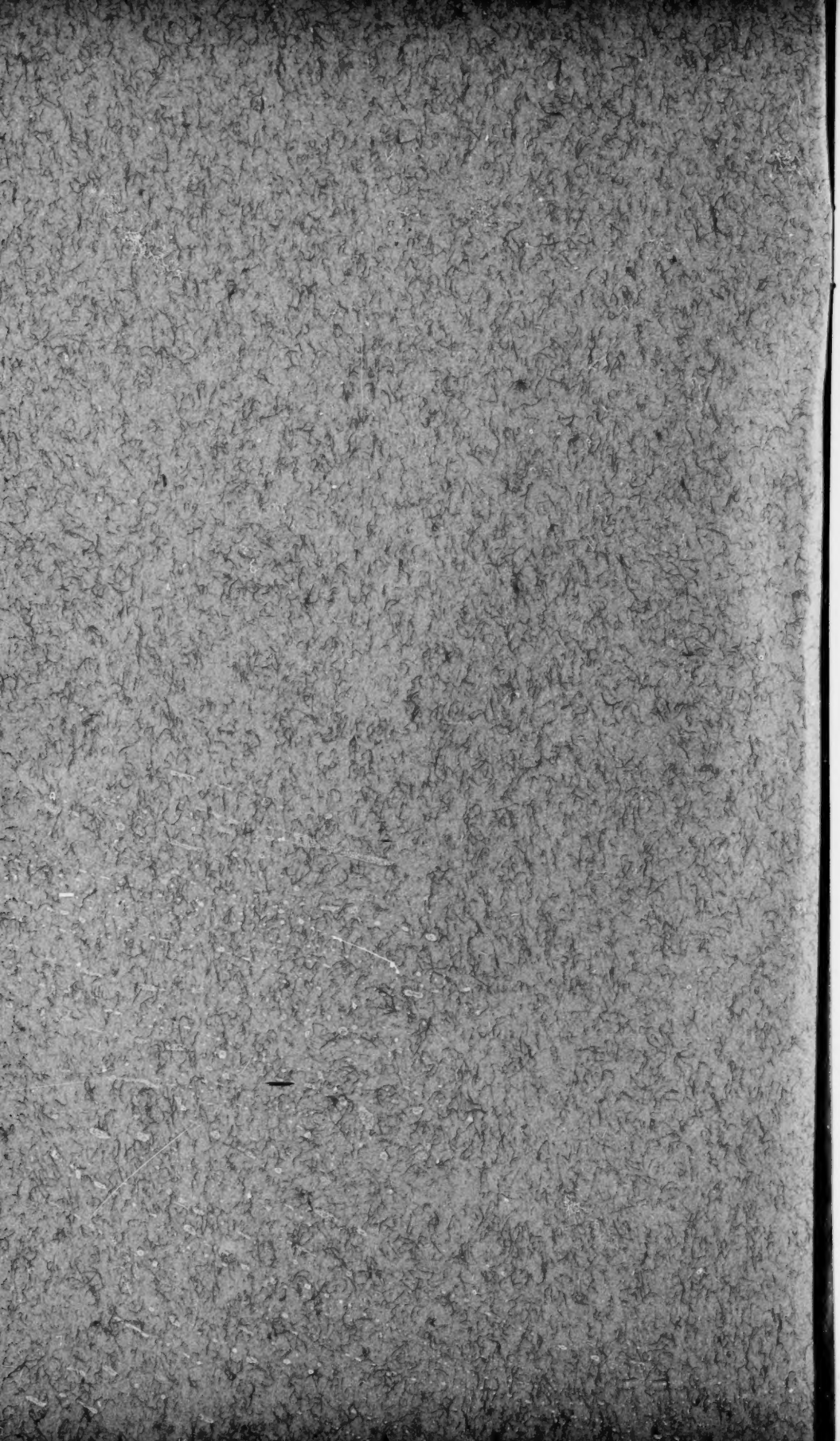

QUESTION PRESENTED

Whether the obligations of a provider of federal employee health benefits under the Federal Employee Health Benefits Act, 5 U.S.C. (& Supp. IV) 8901 *et seq.*, are to be determined solely under the applicable benefits contract between the provider and the Office of Personnel Management (OPM).

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 87-818

KIP HAYES, PETITIONER

v.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. B1-B14) is reported at 819 F.2d 921. The opinion of the district court (Pet. App. A1-A4) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 15, 1987. A petition for rehearing was denied on July 21, 1987 (Pet. App. C1). On October 2, 1987, Justice O'Connor ordered that the time for filing a petition for a writ of certiorari be extended to and including November 18, 1987. The petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Petitioner Kip Hayes is the son of respondent Nobel Hayes, a retired federal employee who, at the times

relevant to this case, was covered by a health benefit plan provided by respondent National League of Postmasters (NLP or Postmasters). As a result of a severe injury, petitioner requires full-time private nursing care. Pet. App. B6.

Respondent Nobel Hayes was enrolled in a health benefit plan provided by respondent Postmasters pursuant to a contract between Postmasters and the federal respondent, Office of Personnel Management (OPM) (Pet. App. B5-B6). The contract between Postmasters and OPM was entered into under the Federal Employees Health Benefits Act (FEHBA), 5 U.S.C. (& Supp. IV) 8901 *et seq*. Under FEHBA, OPM "contracts with various private carriers to develop health care plans with varying coverages and costs. The plans are for a term of one year, and are renegotiated annually." Pet. App. B5. FEHBA contains an express preemption provision, which states that "[t]he provisions of any contract under [FEHBA] which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions" (5 U.S.C. 8902(m)(1)).

In 1982, when Nobel Hayes enrolled in it, the Postmasters plan contained no limit on the amount that would be paid for private duty nursing care. In 1984 and 1985, however, the Postmasters plan "contained a $10,000 limit on benefits for private duty nursing care." Pet. App. B6. The annual cost for private duty nursing care for petitioner substantially exceeds $10,000.

2. In February 1984, Postmasters filed an action in the United States District Court for the Southern District of California (*NLP* v. *OPM*, No. CV-84-0341-LCN) in which it named Nobel Hayes and OPM as defendants and

"sought a declaration that private duty nursing care benefits provided under its 1982 Plan could be reduced in subsequent policy contract years and that under its 1984 Plan Postmasters was not obligated to provide Kip Hayes with private nursing benefits in excess of $10,000" (Pet. App. B6-B7). Although named as a defendant, OPM agreed with the plaintiff, Postmasters, as to the merits.

In April 1984, petitioner brought an action in California Superior Court against Postmasters, Nobel Hayes, and respondent Prudential Insurance Company of America (Prudential) (Pet. App. B7). OPM was not named as a defendant in this action. The suit was removed to the federal district court for the Southern District of California (*Hayes* v. *Prudential*, No. CV-84-1245-LCN) and assigned to the same judge who was handling *NLP* v. *OPM*. In his suit, petitioner "alleged that his enrollment in the 1982 Plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits * * * [and] sought damages alleging various state law causes of action" (Pet. App. B7).

When Postmasters moved for summary judgment in the first action, *NLP* v. *OPM*, petitioner (who was not a party) filed a memorandum of points and authorities in opposition. In a footnote, he requested that the court join him as a defendant in that suit (see OPM C.A. Br. 3-4 n.3). However, petitioner did not serve on the parties a motion to intervene pursuant to Fed. R. Civ. P. 5 and 24(c) (OPM C.A. Br. 3), and the district court never entered an order permitting him to intervene in *NLP* v. *OPM* (*id.* at 3-4).

In *NLP* v. *OPM*, the district court granted summary judgment for Postmasters, finding that "benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 Postmasters Plan and that Postmasters accordingly was not required to pay claims in

excess of that amount" (Pet. App. B7). Similarly, in *Hayes* v. *Prudential*, the district court granted summary judgment in favor of defendants "on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA" (*ibid.* (citation omitted)).

3. Petitioner filed notices of appeal from both judgments to the Ninth Circuit (No. 85-5527 (*Hayes* v. *Prudential*); No. 85-5528 (*NLP* v. *OPM*)); none of the parties in *NLP* v. *OPM*—Postmasters, OPM and Nobel Hayes—filed a notice of appeal from the judgment in that case. In the court of appeals, OPM argued that there was no proper appeal from the judgment in *NLP* v. *OPM* (the only suit to which it was a party), because petitioner, the only appellant, was not plaintiff or a named defendant in that suit and had never properly sought or been granted intervention in it. OPM accordingly moved the court of appeals to dismiss the appeal from *NLP* v. *OPM*, and also moved to intervene in the appeal from *Hayes* v. *Prudential* so that it would be able to present its views on the merits. See OPM C.A. Br. 4-5.

On the jurisdictional question, "[a] motions panel of [the Ninth Circuit] * * * determined that Kip Hayes' appeal in *NLP v. OPM* was effective" (Pet. App. B8). The merits panel explained that "[t]he district court treated appellant's request [to intervene] as a motion for consolidation with *Hayes v. Prudential*, and consolidated the cases. Consolidation by the district court led the motions panel to conclude that Kip Hayes effectively appealed from the summary judgment in *NLP v. OPM*" (*ibid.*).

On the merits, the court of appeals rejected petitioner's arguments under both Postmasters' contract with OPM and state law. Petitioner had claimed that the contract's $10,000 limit was not applicable to him because FEHBA required NLP and Prudential to comply with OPM direc-

tives ordering them to remove it (Pet. App. B8-B9). The court of appeals, however, found that the record indicated "only that OPM unsuccessfully sought Postmasters' voluntary agreement to amend the 1984 contract," and concluded that there were "no legal or factual bases for [petitioner's] claim that Postmasters or Prudential violated a binding OPM directive" (*id.* at B10). The court of appeals also found meritless petitioner's claim that the contract's catastrophic protection provision granted him unlimited benefits, finding instead that the catastrophic provision was governed by the $10,000 limit (*id.* at B10-B11).

The court of appeals then found (Pet. App. B12-B13) petitioner's state law claims preempted by FEHBA (5 U.S.C. 8902(m)(1)), which provides that contract provisions "which relate to the nature or extent of coverage or benefits (including payment with respect to benefits)" preempt inconsistent state law that "relates to health insurance or plans." Petitioner had maintained that his claims related "to the manner in which Postmasters and Prudential *processed* his benefits, and not to the 'nature or extent of coverage or benefits' " (Pet. App. B12-B13 (emphasis in original)), but the court of appeals found that "[t]ort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract" (*id.* at 13 (citation omitted)).

ARGUMENT

Because of the procedural history and posture of this case, there are serious questions as to whether the review sought by petitioner would give him any relief. In any event, the decision below is correct and does not conflict with any decision of this Court or any other court of appeals. Further review is not warranted.

1. Petitioner characterizes the procedural posture of this case in a way which, if correct (and we believe it is not), would very likely render any review by this Court purely advisory. That same possibility would arise were this Court to find—as we believe it would if it were to grant the petition—that the court of appeals erred in finding that petitioner had effectively appealed the judgment in *NLP* v. *OPM*.

a. Although not served by petitioner, OPM is a respondent in this Court: the court of appeals' holding that petitioner had properly appealed from the judgment in *NLP* v. *OPM* (a holding we believe to have been incorrect) necessarily implies that the Ninth Circuit decided a single case, and that OPM was a party to that case.

The district court entered separate judgments in *NLP* v. *OPM* and *Hayes* v. *Prudential* (see No. CV-84-0341-LCN (S.D. Cal. Jan. 22, 1985); No. CV-84-1245-LCN (S.D. Cal. Jan. 22, 1985)); OPM was a party to only one of them. Because petitioner had not been permitted to intervene in *NLP* v. *OPM*, OPM argued in the Ninth Circuit that he could not take an appeal from that judgment. The court of appeals, however, found that petitioner's appeal was effective. It reached that conclusion, not because it thought that petitioner had intervened in *NLP* v. *OPM*, but because it found that the district court had consolidated the two cases. Pet. App. B7-B8. Given that a non-party cannot appeal (*Karcher* v. *May*, No. 85-1551 (Dec. 1, 1987), slip op. 4), it is a necessary premise of the court of appeals' holding that petitioner and OPM had become parties to the same lawsuit. Moreover, since the court of appeals recognized (Pet. App. B8) that petitioner's informal request to intervene in *NLP* v. *OPM* was not granted, the court of appeals must have understood the district court's consolidation of the two proceedings to have made them into one lawsuit. Other-

wise, there would have been no case in which OPM and petitioner were both parties, as to which petitioner could properly appeal.

The court of appeals, then, must be understood to have granted one judgment in one action, an action to which OPM was a party. See Pet. App. B14 (emphasis added) ("The *judgment* of the district court *is* affirmed."). Under Rule 19.6 of the Rules of this Court, "[a]ll parties to the proceeding in the court whose judgment is sought to be reviewed shall be deemed parties in this Court, unless the petitioner shall notify the Clerk of this Court in writing of petitioner's belief that one or more of the parties below has no interest in the outcome of the petition. A copy of such notice shall be served on all parties to the proceeding below * * *." OPM is therefore a party in this Court.

Petitioner, however, neither served OPM nor provided the Clerk and the parties with written notice of his belief that OPM has no interest in the outcome of the petition. Instead, petitioner takes the position that *NLP* v. *OPM* and *Hayes* v. *Prudential* remain two entirely distinct proceedings, and that he can seek certiorari solely as to the latter, in which OPM is not a party.[1] This view contradicts that of the court of appeals and fails to explain how petitioner was able to appeal *NLP* v. *OPM* to the court of appeals, if he and OPM had never become a party to the same suit.

But even if petitioner is correct in believing that he may seek review only as to *Hayes* v. *Prudential*, it would be unwise to grant the petition. Review of the judgment in *Hayes* would not disturb the judgment in *NLP* v. *OPM*, in which the benefit provider (Postmasters) prevailed against the primary plan enrollee—petitioner's father, Nobel

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[1] This position is expressed in a letter from petitioner to the Clerk of this Court, dated January 25, 1988, opposing our motion for an extension of time within which to file this brief.

Hayes. Accordingly, before it could even address the merits, this Court would have to decide whether Postmasters' judgment against petitioner's father precludes any recovery by petitioner; otherwise, any decision in this case would be advisory. Petitioner suggests no reason to believe that he would prevail on that preliminary inquiry, or that resolving it would be a worthwhile use of this Court's resources.

b. Moreover, that same preliminary issue would arise even if petitioner is wrong about OPM's status as a party in this Court, because the court of appeals was wrong about petitioner's appeal of *NLP* v. *OPM*. The court of appeals treated the district court's consolidation of *NLP* v. *OPM* and *Hayes* v. *Prudential* as if it merged the two cases, making every party to one a party to the other. In so holding, the court of appeals misinterpreted the district court's order. As a general matter, consolidation does not make the parties to the consolidated actions all parties to one lawsuit.[2] In this case, moreover, the district court declined to grant petitioner's motion to intervene in *NLP* v. *OPM* and issued two separate judgments. Petitioner and OPM therefore never became parties to the same suit, and petitioner could not appeal from the judgment involv-

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[2] "[C]onsolidation does not cause one civil action to emerge from two; the actions do not lose their separate identity; the parties to one action do not become parties to the other. *Alfred Dunhill, Inc. v. Republic of Cuba*, 425 U.S. 682, 735, 96 S. Ct. 1854, 1880, 48 L.Ed.2d 301 (1976) (Marshall, J., dissenting); 9 C. Wright & A. Miller, Federal Practice and Procedure § 2382, at 255 (1971); 5 Moore's Federal Practice ¶ 42.03[3], at 42-27 to 42-29 (2d ed. 1982); *see Johnson v. Manhattan Railway Co.*, 289 U.S. 479, 496-97, 53 S.Ct. 721, 727-28, 77 L.Ed. 1331 (1933)." *McKenzie* v. *United States*, 678 F.2d 571, 574 (5th Cir. 1982); see also *Cole* v. *Schenley Indus., Inc.*, 563 F.2d 35, 38 (2d Cir. 1977) ("consolidation cannot effect a merger of the actions").

ing OPM. Thus, if this Court were to grant the petition, but ultimately found that the court of appeals had no jurisdiction over *NLP* v. *OPM*, it would again face a serious question whether any ruling on the merits would be purely advisory.

2. In any event, the court of appeals was correct and its decision does not conflict with that of any other court of appeals. The Ninth Circuit began its treatment of the merits by determining that under Postmasters' contract with OPM, petitioner was not entitled to private duty nursing care expenses in excess of $10,000 per year (Pet. App. B8-B11). (Petitioner does not appear to seek review of this initial holding.) In addition, petitioner had asserted a number of state law claims against the non-federal respondents (*id.* at B12 n.1). The court of appeals, however, held those claims preempted by 5 U.S.C. 8902(m)(1), since they "invariably expand [respondents'] obligations under the terms of the Plan" (Pet. App. B13).

That conclusion was plainly correct. Section 8902(m)(1) states that the provisions of any benefit contract between OPM and a benefit provider "which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law * * * [that is] inconsistent with such contractual provisions." It is difficult to imagine a more explicit way of saying that the nature and extent of benefits are determined solely by the contract, and that state law cannot create any additional right to benefits. The entire point of petitioner's state law claims, however, was to create an obligation to pay benefits where the contract (as the court of appeals held) had not imposed one.[3] Section 8902(m)(1)

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[3] Petitioner attempts to create the impression (*e.g.*, Pet. 16, 27, 30) that the issue in this case is whether he has any remedy for violations of his rights to benefits. However, the only question presented con-

preempts any state law that would do so.[4]

There is no inconsistency among the courts of appeals on this question.[5] Petitioner argues (Pet. 15-20) that the Ninth Circuit's decision conflicts with that in *Howard* v. *Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984). But the only question in *Howard* was whether a claim for breach of a federal health benefits contract was removable to federal court; the Tenth Circuit held that the district court lacked subject matter jurisdiction because the suit was "a private controversy in which the federal government simply does not have an interest sufficient to justify

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cerns the scope of petitioner's rights, not the remedies available to effectuate those rights. The Ninth Circuit held that petitioner had no right to reimbursement for private duty nursing care expenses in excess of $10,000 per year under the contract and that California law could not provide such a right because of Section 8902(m)(1). No question of remedy, state or federal, was presented. For that reason, petitioner's discussion (Pet. 21-28) of implied causes of action under FEHBA is beside the point.

[4] Petitioner also argues (Pet. 28-30) that Section 8902(m)(1) should not be read as preempting state laws that regulate insurance providers because of the McCarran-Ferguson Act, 15 U.S.C. 1012. Contracts between benefit providers and OPM, however, are federal procurement contracts, not insurance in the ordinary sense of that word. See S. Rep. 95-903, 95th Cong., 2d Sess. 8 (1978). Thus, there is no conflict between Section 8902(m)(1) and the McCarran-Ferguson Act.

[5] Petitioner suggests (Pet. 28-30) that the Ninth Circuit's decision here conflicts with a decision of the California Court of Appeal, *Fields* v. *Blue Shield*, 163 Cal. App. 3d 570, 209 Cal. Rptr. 781 (1985). *Fields*, however, appears to be in tension with another California Court of Appeal's decision, *Hartenstine* v. *Superior Court*, 196 Cal. App. 3d 206, 241 Cal. Rptr. 756 (1987), which is in turn consistent with the decision below. Thus, even if a conflict between the views of a state court and a federal court of appeals warranted review by this Court—which it ordinarily does not—the position of the California courts has yet to be clarified by the Supreme Court of California.

invoking federal question jurisdiction" (*id.* at 1512). Accordingly, *Howard* presented a completely different issue from this case: whether an attempt to recover under the terms of a federal benefits contract arises under federal laws, not whether an attempt to add to the provisions of a federal benefits contract is preempted by federal law. Indeed, the Tenth Circuit specifically determined that no issue of preemption was presented under Section 8902(m)(1), finding "no indication that any law of Oklahoma conflicts with the medical necessity or any other provision of the Blue Cross contract" (739 F.2d at 1510 n.1).[6]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

CHARLES FRIED
Solicitor General

FEBRUARY 1988

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[6] *Howard*, moreover, was decided before this Court's explicit preemption decision in *Pilot Life Ins. Co.* v. *Dedeaux*, No. 85-1043 (Apr. 6, 1987), on which the Ninth Circuit in this case correctly relied (Pet. App. B13).

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